DOCUMENT RESUME

ED 466 916 EC 309 064

TITLE	Ritalin Use among Youth: Examining the Issues and Concerns. Hearing before the Subcommittee on Early Childhood, Youth and Families of the Committee on Education and the Workforce. House of Representatives, One Hundred Sixth Congress, Second Session.
INSTITUTION	Congress of the U.S., Washington, DC. House Committee on Education and the Workforce.
REPORT NO	House-Hrg-106-109
PUB DATE	2000-05-16
NOTE	145p.
AVAILABLE FROM	Government Printing Office, Superintendent of Documents, Congressional Sales Office, Washington, DC 20402-9328. Tel: 202-512-1800. For full text: http://edworkforce.house.gov/index.htm.
PUB TYPE	Legal/Legislative/Regulatory Materials (090)
EDRS PRICE	EDRS Price MF01/PC06 Plus Postage.
DESCRIPTORS	*Attention Deficit Disorders; Clinical Diagnosis; *Drug Abuse; *Drug Therapy; Educational Environment; Educational Trends; Elementary Secondary Education; Hearings; *Hyperactivity; *Incidence; *Outcomes of Treatment; Personal Narratives; Substance Abuse; Trend Analysis
IDENTIFIERS	Congress 106th; *Ritalin

ABSTRACT

This document contains the proceedings of a hearing held on May 16, 2000, before the U.S. House of Representatives Subcommittee on Early Childhood, Youth, and Families. The hearing addressed issues and concerns on the use of ritalin among youth with attention deficit hyperactive disorder (ADHD). Following opening remarks of the congressmen, the report includes the testimony of Terrance Woodworth, the Deputy Director of the Office of Diversion Control at the Drug Enforcement Administration. In his testimony, he describes the increases in the production, distribution, and use of methylphenidate, and the lax handling of medication at schools that has provided an opportunity for abuse. The testimony of Dr. Lawrence Diller, a behavioral pediatrician, follows and addresses the over-prescription of ritalin. The testimony of special educator Francisca Jorgensen is then provided. She discusses a child with ADHD, who, after several unsuccessful educational accommodations, was provided with ritalin. Using ritalin, the student was able to attend, pay attention, and better relate to his peers. Following her testimony, the testimony of Mary Robertson, a mother of two children with attention deficit hyperactivity disorder, is provided. She discusses the benefits of ritalin. The appendices include official statements from the congressmen, witnesses, and interested parties. (CR)

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ED 466 916

RITALIN USE AMONG YOUTH: EXAMINING THE ISSUES AND CONCERNS

HEARING

BEFORE THE

SUBCOMMITTEE ON EARLY CHILDHOOD,
YOUTH AND FAMILIES

OF THE

COMMITTEE ON EDUCATION AND
THE WORKFORCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

HEARING HELD IN WASHINGTON, DC, MAY 16, 2000

Serial No. 106–109

Printed for the use of the Committee on Education and the Workforce

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RITALIN USE AMONG YOUTH: EXAMINING THE ISSUES AND CONCERNS

TUESDAY, MAY 16, 2000

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON EARLY CHILDHOOD, YOUTH AND FAMILIES,
COMMITTEE ON EDUCATION AND THE WORKFORCE,
WASHINGTON, D.C.

The subcommittee met, pursuant to call, at 2:30 p.m., in Room 2175, Rayburn House Office Building, Hon. Michael N. Castle [chairman of the subcommittee] presiding.

Present: Chairman Castle, Goodling, Petri, Roukema, Schaffer, DeMint, Kildee, Payne, Woolsey, Hinojosa, Ford, Kucinich, and Wu.

Staff Present: Becky Campoverde, Communications Director; Linda Castleman, Office Manager; Victor Klatt, Education Policy Coordinator; Dan Lara, Press Secretary; Sally Lovejoy, Senior Education Policy Advisor; Patrick Lyden, Professional Staff Member; Krisann Pearce, Professional Staff Member; Michael Reynard, Media Assistant; Bob Sweet, Professional Staff Member; Kevin Talley, Staff Director; Shane Wright, Legislative Assistant; June Harris, Minority Education Coordinator; Alex Nock, Minority Legislative Associate/Education; and Roxana Folescu, Minority Staff Assistant/Education.

OPENING STATEMENT OF CHAIRMAN MICHAEL CASTLE, SUBCOMMITTEE ON EARLY CHILDHOOD, YOUTH AND FAMILIES, COMMITTEE ON EDUCATION AND THE WORKFORCE, U.S. HOUSE OF REPRESENTATIVES, WASHINGTON, DC

Chairman Castle. A quorum being present, the Subcommittee on Early Childhood, Youth and Families will come to order.

We are meeting today to hear testimony on the issues and concerns surrounding the use of Ritalin. I am eager to hear from the two distinguished panels we have before us today. But before we begin opening statements, I ask unanimous consent for the hearing record to remain open 14 days to allow members' statements and other documents to be submitted in the official hearing record.

Without objection, so ordered.

I will yield myself 5 minutes for my opening statement.

I do thank everybody for being here today. I appreciate everyone's interest in this topic, and I do look forward to an informative hearing.

Ritalin is prescribed to help children who have attention deficit disorder, ADD, and attention hyperactivity disorder, ADHD, commonly called ADD/ADHD.

Our witnesses can provide a more thorough explanation, but the symptoms of children with ADD/ADHD can include inattention and restlessness, which may simply be youthful rambunctiousness, or it may be that the child is acting out in response to serious stressors like divorce or neglect, or it may be that the child does have ADD/ADHD.

The bottom line is that it is difficult to make an accurate diagnosis, especially among young children, unless a physician makes a through evaluation of all aspects of the child's life.

With that said, according to studies and anecdotal evidence, Ritalin can help some students focus and curb their impulses. Keep in mind, however, that Ritalin can help anyone be more attentive. It is an amphetamine, and it is not so dissimilar from speed.

Just because Ritalin helps some children, it does not mean that it is a cure. As a constituent of mine once put it, kids can learn to live with a learning disability, and they can deal with their emotions if they have help. Kids whose symptoms are banished with drugs only get drugs, not help and not long-term solutions for their problems.

In late February of this year, a news report on the increasing use of Ritalin caught my attention. I was particularly alarmed by the finding that, for the years 1991 to 1995, the number of children ages 2 to 4 who were prescribed psychotropic drugs, including Ritalin, increased by 50 percent. The researchers commented that these findings were remarkable given the lack of research on the drug's effect on children of this very young age, and they found that school-aged youth also showed increases in the use of Ritalin.

I initiated today's hearing to provide a forum to discuss the issues surrounding the use of Ritalin. Personally, I have many concerns about the use of Ritalin. I hear reports of students are selling Ritalin at school and that schools are reporting thefts of Ritalin under their control during the school day.

I also hear that youth find it easy to abuse their own prescribed Ritalin or a friend's Ritalin, such as by snorting it for a better high. As we all know, Ritalin is a schedule II drug regulated by the DEA. Yet it is a drug to which many youth have relatively easy access.

Additionally, I am greatly concerned by the lack of research on the long-term effects of Ritalin. We do not know what the long-term effects are for the child who takes Ritalin for 10 or 20 years. As the chairman of the Harvard Medical School Department of Psychiatry has stated, the period between birth and age 4 especially is a time of tremendous change and maturation; and, at the very least, we need to be very cautious in both the identification of all ADD/ADHD children and their treatment.

Finally, there have been questions raised with respect to these drugs and acts of violence in our classrooms. Some use as evidence the fact that at least one of the gunmen in the recent school shootings was reported to be on a drug like Ritalin. Whatever the answer, we need a serious discussion about whether it can cause violent behavior or, if not, whether these drugs are sufficient to prevent it.

Clearly, the Congress and the public need more information in order to weigh the benefits and harms of prescribing Ritalin and other drugs to our children. As we will likely hear from our witnesses, the decision of whether to use Ritalin is a decision to which the child's parents, teachers and doctor should all have input. I believe the information discussed this afternoon will assist in this decision.

I thank you.

[The statement of Chairman Castle follows:]

OPENING STATEMENT OF CHAIRMAN MICHAEL CASTLE, SUBCOMMITTEE ON EARLY CHILDHOOD, YOUTH AND FAMILIES, COMMITTEE ON EDUCATION AND THE WORKFORCE, U.S. HOUSE OF REPRESENTATIVES, WASHINGTON, DC – SEE APPENDIX A

OPENING STATEMENT OF RANKING MEMBER, DALE KILDEE, SUBCOMMITTEE ON EARLY CHILDHOOD, YOUTH AND FAMILIES, COMMITTEE ON EDUCATION AND THE WORKFORCE, U.S. HOUSE OF REPRESENTATIVES, WASHINGTON, DC

Mr. Kildee. Mr. Chairman, I will submit my statement for the record so we can hear from the witnesses.

[The statement of Mr. Kildee follows:]

OPENING STATEMENT OF RANKING MEMBER DALE KILDEE, SUBCOMMITTEE ON EARLY CHILDHOOD, YOUTH AND FAMILIES, COMMITTEE ON EDUCATION AND THE WORKFORCE, U.S. HOUSE OF REPRESENTATIVES, WASHINGTON, DC – SEE APPENDIX B

Chairman Castle. Thank you. Mr. Kildee is the ranking member, by the way. Chairman Goodling has a statement he wishes to make.

OPENING STATEMENT OF THE HONORABLE BILL GOODLING, SUBCOMMITTEE ON EARLY CHILDHOOD, YOUTH AND FAMILIES, COMMITTEE ON EDUCATION AND THE WORKFORCE, U.S. HOUSE OF REPRESENTATIVES, WASHINGTON, DC

Mr. Goodling. Mine will be brief, because the staff that wrote this statement are too kind and too gentle.

I happen to think that Ritalin may be the greatest drug problem we have in the country, and it drives me up the wall to see little children get hooked so early. Having been an educator and listening to my wife the last 40 years as a first grade teacher in an affluent district and watching the dramatic increase of Ritalin being pushed down those kids' throats, she would come home crying because, in many instances, she would say the only problem with the child is the child needs to be challenged.

Now, obviously, there are children out there who need to be medicated, but I think we are just going overboard. She went back to that same district to substitute this year for a couple of weeks, and she said, the brightest kid in the class, every day they have the poor child medicated; and she said the only thing that the child needs is to be challenged, that particular child, constantly.

And I said, well, you are retired. Therefore, you don't have to put up with that. Just send a note home and say, if you can't stand the kid at home, fine, medicate him at home, but don't send him to me. I can take care of him and challenge him and challenge all the other students in my class.

So we have to find, very quickly, I think, where that level is, where it is legitimate and where it isn't legitimate, where teachers just don't have the time or the desire and, therefore, encourage it, or parents who don't have the time to deal with hyperactive children.

So let us find where it is legitimate and where it is not legitimate and let us not hook little children on a tremendous drug so early in their life or any time in their life.

I will submit this nice, gentle piece, very well written, for the record.

[The statement of Mr. Goodling follows:]

OPENING STATEMENT OF THE HONORABLE BILL GOODLING, SUBCOMMITTEE ON EARLY CHILDHOOD, YOUTH AND FAMILIES, COMMITTEE ON EDUCATION AND THE WORKFORCE, U.S. HOUSE OF REPRESENTATIVES, WASHINGTON, DC – SEE APPENDIX C

Chairman Castle. Thank you, Mr. Chairman. Our rules provide for an opening statement by the chairman of the subcommittee and the ranking member. We made the exception today for the chairman of the full committee, which means that we should offer it to the other side, the opportunity to make one additional opening statement, if anybody wishes to. Mr. Kildee waived his. Ms. Woolsey, she would like to submit hers.

OPENING STATEMENT OF THE HONORABLE LYNN WOOLSEY, SUBCOMMITTEE ON EARLY CHILDHOOD, YOUTH AND FAMILIES, COMMITTEE ON EDUCATION AND THE WORKFORCE, U.S. HOUSE OF REPRESENTATIVES, WASHINGTON, DC

Ms. Woolsey. I will be very, very short.

I just want to thank you, Mr. Castle, for having this hearing. This is something I have been ranting and raving about over the last--not gently--for the last 3 to 5 years. Yes, some children need it. I want to find out who does. But, boy, I am telling you, it is being over-used, and we are making a huge mistake.

So thank you for having this hearing. We can learn where the mistake is and where we could do something about it.

Chairman Castle. Well, thank you, Ms. Woolsey.

There has been a lot of interest in this particular hearing. In fact, we have had the requests by two of our more distinguished Members in the House to come before us to speak, and they will be part of the first panel.

The first of those will be the Honorable Deborah Pryce, who is currently serving her fourth term, which I know well since we came together, as a representative of Ohio's 15th district. Her role as House Conference Secretary, Deputy Majority Whip and member of the Rules Committee typifies Representative Pryce's active and influential standing within the House of Representatives. Prior to her service in Congress, Representative Pryce served as a presiding judge in the Franklin County Municipal Court in Ohio.

The Honorable Dennis Kucinich is currently serving his second term as a representative of the 10th district also of Ohio. In addition to his distinguished work on this committee, he cochairs both the House Aviation and Space Caucus and the Baltic Caucus. Prior to being elected in 1996, he served as both a State senator in his home State of Ohio and Mayor of Cleveland.

We are pleased to have both of you. We are actually going to turn the clock off for you, but we still have a gavel just in case it really goes south on us.

Chairman Castle. We will start with Ms. Pryce.

STATEMENT OF THE HON. DEBORAH PRYCE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Ms. Pryce. Thank you, Mr. Chairman. I appreciate that kind introduction. And, members of the subcommittee, I appreciate you holding this important hearing and giving me the opportunity to testify today.

At the outset, let me offer a disclaimer. I certainly am not an expert on Ritalin, any psychiatric drug or child development. Instead, I appear before you as a representative to Congress who has heard from many, many constituents who are very concerned about the increased use of Ritalin among children. I would like to describe for you their views as they relayed them to me.

The first time concerns about Ritalin were raised with me was in 1995 when I met with the Ohio State Board of Pharmacy. They were concerned about an increase in the use of Ritalin among school-aged children in Ohio and the pressure placed on school nurses and parents to put children on the drug. They suggested that some perverse financial incentives may be in play, in that schools receive more funding if more students were diagnosed with attention deficit disorder.

Another concern the Board of Pharmacy had was that the increase of Ritalin as a street drug was due to the over-prescription and misuse by some. Ritalin, intended for attention deficit children, was making its way to the street corner.

More recently, I have been contacted by parents of school-aged children. The father of a 6-year-old wrote to me because his child, who he described as, quote, a handful, but not, quote, out of control, was diagnosed with attention deficit hyperactivity disorder, also known as ADHD.

Interestingly, this parent claims the teacher provided the diagnosis, and the school is pressuring the parents to put their child on Ritalin. The parents have tried to find alternatives that may change their son's behavior, but apparently the effects of these other remedies are not dramatic enough to assuage the school's concerns about the boy's behavior. Therefore, my constituent remains under pressure to put his child on Ritalin; and he is under the impression that, unless he complies, his son may no longer be able to attend school.

Now, according to the parents of this young boy, they are not alone in their predicament. They have met many other parents along the way who had had similar experiences.

Another constituent who wrote to me has an 11-year-old son who is active and, according to his mom, has trouble, quote, sitting still in class. However, this mother does not believe her son has a behavior problem, as he is respectful of adults and of authority. The school has a different impression.

A few years ago, they began sending his mother pamphlets on ADHD. This mother claims that she is forced to take her son to the doctor, and he now takes drugs to control the problem. In the view of this parent, the school's pressure on her is due to the school's inability and unwillingness to discipline the children which, in her view, is partly driven by the laws that we legislators pass.

This particular parent makes another observation which has been reported in the press, which is that the use of these drugs may be related to violence in schools.

My first thought is that is not surprising that children prone to violence may also be candidates for the use of psychiatric drugs. However, one doctor who is opposed to the use of Ritalin told CBS News that she believes Ritalin, which she says is also identical to cocaine, can cause dangerous behavior. Now, this is a very bold statement about a drug that has been in use for 40 years and which most physicians would probably tell us is very safe. However, I bring it to this subcommittee's attention because I know you have been studying the causes of school violence and working to reduce it.

I am not interested in placing any blame or judging these parents, their children or the school personnel that must deal with these mischievous and/or delinquent children, but the issue presents an interesting dynamic among schools, parents and the medical community. At first blush, you would think that Ritalin is a medical issue, but the input from my constituents reveals that the schools are very, very much involved.

Unfortunately, doctors cannot observe the behavior that prompts school personnel to suggest that the child may have a medical problem. Even the parents cannot see how their child behaves when he or she is in the classroom environment and not at home.

It seems to me that making this type of health diagnosis is quite difficult and time-consuming, and I am not sure that anyone but the teachers have spent the time observing the behavior in question before children are diagnosed. I am pleased that the subcommittee has also invited a teacher to testify today to provide a school's perspective.

I am also not prepared to question the effectiveness of Ritalin or other psychiatric drugs, nor do I have a comment about the doctors who prescribe these drugs to children. I am sure that these drugs have been proven quite effective in many, many cases. However, after receiving these letters from my constituents and reading recent reports about the growing numbers of very young children who are using psychiatric drugs Nationwide, I felt congressional inquiry was warranted.

Now, as already mentioned by the chairman, so I am sure the subcommittee is well aware that the report published in the Journal of American Medical Association in February found that between 1991 and 1995 the number of 2- to 4-year-olds using this drug increased 50 percent. I think that trend raises another very important issue which is relevant to the Federal Government's role in drug safety, though perhaps not in this subcommittee's jurisdiction.

I think it is very important that we devote resources to the study and provide better information to parents about long-term effects of drugs on children.

It was just a few years ago that we heard about the important discoveries in the area of brain development in children ages zero to 3. In fact, studies show that 75 percent of brain growth development is in the first 3 years of a child's life. From a layman's perspective, it seems somewhat alarming to me that children as young as 2 years old are taking psychiatric drugs, and I believe it is incumbent upon the government to determine the risks of prescribing such drugs to such very young children.

I want to reiterate that I am not here to cast judgment on individuals or the efficacy of any drug. However, it appears to me from the firsthand accounts that people in my own community that there is adequate public concern to warrant your attention.

I thank the subcommittee for holding today's hearing, which I hope will be helpful in improving our understanding of the many issues surrounding the growing use of psychiatric drugs by our children.

I thank you, Mr. Chairman. And I am late for a leadership meeting, if you have any questions, I would be happy to spend a minute answering them.

[The statement of Ms. Pryce follows:]

STATEMENT OF THE HONORABLE DEBORAH PRYCE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO – SEE APPENDIX D

Chairman Castle. Thank you very much, Representative Pryce. We have an hour's worth of questioning. No, I'm just kidding. I don't think we do have any questions. We really appreciate you being here. We know your schedules are very difficult. We certainly will not try to burden--Mr. Kucinich can ask questions, by the way. He is on this subcommittee, so he is easy. But we do appreciate your being here, and you are certainly excused to go now.

Ms. Pryce. I appreciate that.

Chairman Castle. Good luck in your meeting. Our next speaker, already introduced, is the distinguished gentleman, also from Ohio, Representative Kucinich.

STATEMENT OF THE HON. DENNIS KUCINICH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. Kucinich. Thank you very much.

I want to say, as Representative Pryce is leaving, I appreciate her testimony.

I appreciate the opportunity, Mr. Chairman, Mr. Kildee, members of the subcommittee, the subcommittee on which I proudly serve. I appreciate this opportunity to testify before the subcommittee on efforts to gather information on the increased use of Ritalin and related drugs by youth. I appreciate this opportunity to be here with Congresswoman Pryce, and I am grateful for her testimony.

I want to take a few minutes before the expert panel comes forward to describe a situation experienced by my constituents in Cleveland and the western suburbs I represent.

This issue first came to my attention following an investigative series by Cleveland WKYC-TV, Channel 3, which is the NBC affiliate serving Northeast Ohio. In a revealing series of investigative reports, a series that was spearheaded by investigative reporter Phil Hayes, Channel 3 unearthed a pattern of abuses involving a number of young students in the greater Cleveland area whose parents were being pressured to seek a Ritalin prescription for their child by a small number of well-intentioned, but misinformed, school administrators and teachers.

What Channel 3 revealed was a disturbing pattern of abuses, where schoolteachers and administrators faced with a student with a discipline problem, with an unruly student or a hyperactive student, were using their positions as authority figures in the classroom to encourage parents to seek physicians for the sole purpose of obtaining a Ritalin prescription for their child.

Well-meaning teachers and counselors with no real medical background were unwittingly supplanting the judgment of a trained physician, whose diagnosis should be paramount in determining the cause and solution for a student who may or may not be just suffering from attention deficit disorder, known as ADD, or attention deficit hyperactivity disorder, known as ADHD.

Imagine being a parent and having a schoolteacher or a counselor say to you the only way to help, or save, your child was to obtain a Ritalin prescription.

I am not a physician, but I have been in the classroom as both a regular visitor in local elementary, middle and high schools and also an instructor at a college level. I know firsthand the challenges teachers and school counselors face with unruly students with discipline problems.

I know how frustrating it can be when one student can disrupt the learning opportunities of an entire classroom, and I recognize that parents of such children desperately want to find a solution, any solution to help their child learn and reach their full potential.

But what Channel 3 exposed was an apparent and alarming collective assumption by school officials that Ritalin was the only option that parents should seek to help their child address the behavioral problem and that the advice of someone other than a physician could be instrumental in making that determination.

Ritalin may have its appropriate application in certain circumstances, and there certainly are a number of parent whose are convinced that Ritalin helped their child overcome a behavioral problem, but that determination must be made by a qualified physician in consultation with the child's parents or guardian.

Now, following the Channel 3 investigation, Mr. Chairman, members of the subcommittee, I worked with my Cleveland congressional colleague, Representative Stephanie Tubbs Jones, to have the Ohio Department of Education hold a series of seminars last fall throughout the State of Ohio for school administrators and counselors. The seminars focused primarily on the appropriate procedures for the identification and treatment of students with attention deficit and attention hyperactivity disorder.

This subcommittee can play a meaningful role, as channel 3 did, in educating school systems on the appropriate procedures that can help parents and children faced with this dilemma.

Ritalin should not be the only option forced on parents and their children. There are other options. They don't have to be forced. And with the advice and determination of a qualified physician, parents can determine that there may exist a better option.

I think that Chairman Goodling's remarks were well taken. We have to be very concerned that we are not creating a climate where we feel that there is a chemical answer to every problem that comes up, where sometimes it is human interaction, sometimes it is the human factor, as Mr. Chairman was addressing, where people work with children and try to help them through their difficulties and find out if there is another way to get them to where they can function better other than to simply reach for a prescription just like that.

I thank you, Mr. Castle, and members of the committee.

[The statement of Mr. Kucinich follows:]

STATEMENT OF THE HONORABLE DENNIS KUCINICH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO – SEE APPENDIX E

Chairman Castle. Thank you, Representative Kucinich. I don't know if any of the members here have any questions. I hope you will join us and be part of the conversation as we go forward, and we very much appreciate your testimony. We will now move to the second panel.

Mr. Kucinich. Thank you.

Chairman Castle. We will go from there.

The second panel, we will put out the name tags so they will know where to go for starters. You know who you are.

By the way, we did have a vote earlier when we were supposed to begin at 2 o'clock. We do not anticipate any vote votes now for a long enough period of time to finish, we think, the panel and the questions. So, hopefully, we will be able to get through it. Although, you never know exactly what is going to happen on the floor here, for sure. .

Let me start to introduce the witnesses while they take the places.

The first witness will be Terrance Woodworth, who is a Deputy Director of the Office of Diversion Control within the Drug Enforcement Administration in Washington, D.C. He began working with the Bureau of Narcotics and Dangerous Drugs, a predecessor to DEA, nearly 30 years ago and has since served in a variety of positions within the organization.

Our second witness on this panel will be Dr. Lawrence Diller, a specialist in behavioral and developmental pediatrics, who runs his own practice in Walnut Creek, California. He has published extensively on family therapy and childhood psychology; and, in 1998, he released Running On Ritalin, A Physician Reflects on Children's Society and Performance in a pill.

Our third witness will be Mrs. Francisca Jorgensen, who teaches fifth grade special education students in Arlington County when she has worked for the past 12 years as a special education resource teacher, a self-contained classroom teacher, and a case manager for students with individualized education plans. Ms. Jorgensen has also taught at the Lab School of Washington, a private school dedicated to educating students with learning disabilities.

And our final witness in this panel will be Mrs. Mary Robertson, who is a parent of a child with attention deficit disorder, is a past president of Child and Adults with Attention Deficit Hyperactivity Disorder, CHADD, a registered nurse with a Bachelor of Science in nursing. She has also directed the ADD clinic at the Columbia Counseling Center in Lexington, Kentucky, cofounded the first CHADD chapter in Kentucky and founded the Kentucky CHADD State Council.

So we have four very qualified witnesses for what is a very significant subject in which there obviously is a lot of public interest. In order to give members, we have quite a few here, the time to ask questions, we do ask that you do keep your statements within 5 minutes. It is a little bias we have for the members. We might have let them go over 5 minutes.

The lights will tell you what you have. The first four minutes are green, then it turns yellow for the sort of like stop lights, it turns yellow for the last minute, and then it gets red after that. And, hopefully, when you see the yellow, you start thinking about closing and try to close as rapidly as possible when it gets to red.

After you are all through testifying, we will go through all four statements. The members will alternate one side to the other, will have an opportunity to have 5 minutes to ask you and to get your answers, and they may in some times try to hurry you a little on the answers so they can go on to whatever their other questions are. Please excuse that when, not if, but when that happens, because it will. But we really appreciate you being here.

It is always an inconvenience, we know, to get here and sometimes we have this distractions like votes on the floor, et cetera. So we are very appreciative of that. And from this point on, we will go strictly in order. I will call you on between the various witnesses.

Chairman Castle. We will start with Mr. Woodworth.

STATEMENT OF MR. TERRANCE WOODWORTH, DEPUTY DIRECTOR, OFFICE OF DIVERSION CONTROL, DRUG ENFORCEMENT ADMINISTRATION, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, D.C.

Mr. Woodworth. Good afternoon, Mr. Chairman. May I request that my written statement be submitted for the record?

Chairman Castle. That is a good point. And the written statement of all of you will be submitted for the record, without objection.

Mr. Woodworth. Thank you. Mr. Chairman, distinguished members of the subcommittee, I want to thank you for the opportunity to address you today on behalf of the Drug Enforcement Administration Acting Administrator, Donnie Marshal.

The DEA, through enforcement of the Controlled Substances Act, is the agency responsible for the regulation and control of substances with abuse potential. Only two such controlled substances are widely used by American physicians to treat children: methylphenidate, commonly known as Ritalin, and amphetamine, primarily Adderall and Dexedrine.

Both are approved and used in the treatment of attention deficit hyperactivity disorder, referred to as ADHD or ADD. Both of these substances are powerful stimulants with high abuse potentials and are subject to the highest level of control available for pharmaceutical drugs. RPTS LAD

Since the early 1990s, there have been significant increases in the production, distribution, and use of methylphenidate. Increases in the production and use of amphetamine are more recent. The methylphenidate production quota has increased from about two metric tons in 1990 to nearly 15 metric tons this year, and domestic sales have increased by nearly 500 percent.

The amphetamine production quota has increased from less than half a ton in 1990 to over nine metric tons this year. That is more than a twenty-fold increase for amphetamine in nine years. United Nations data show that the U.S. Produces and consumes about 85 percent of the world's supply of methylphenidate. After a sharp increase in the use of methylphenidate in the early '90s, prescriptions have leveled off at about 11 million per year for the past four years.

However, amphetamine prescriptions, primarily Adderall, have increased dramatically since 1996, from about 1.3 million to nearly 6 million. The net result is that prescriptions written for ADHD have increased by a factor of five since 1991. Additionally, in 1998, about 40 percent of all stimulant medications for ADHD were written for children three to nine years of age, and 4,000 methylphenidate prescriptions were written for children two years of age or younger.

It is important to note that methylphenidate is not approved for use in children under six years of age because safety and efficacy has not yet been established.

The DEA distribution data indicate that there is a wide variable in the use of methylphenidate and amphetamine from one state to another, and from one community to another within states. In some high-use areas, 10 to 20 percent or more of the students are diagnosed with ADHD and prescribed stimulants. These percentages are much different than the published ADHD prevalence of 3 to 5 percent.

Diversion of methylphenidate has been identified by drug test, illegal sales, forged prescriptions, various scams involving doctor shopping. In addition, DEA has received a number of reports of methylphenidate theft at unregistered locations, primarily at schools and homes where methylphenidate supplies are kept.

While state and federal laws require accountability of controlled substances by licensed handlers, no such requirements are imposed at schools. The lax handling of medication at school has provided an opportunity for some individuals to divert and abuse them. For example, a highly respected teacher was videotaped stealing methylphenidate from the nurse's office the evening of the awards ceremony that was honoring him as teacher of the year.

In another incident, a school principal took students' methylphenidate prescriptions, forged his name and filled them at pharmacies for his own personal use. In another example, a student who left home with a month's supply of medication arrived at school with only six tablets, having distributed the others to friends on the way to school.

Schools have been broken into and medication supplies have been taken. In some cases, school officials had no idea of how much or whose medication was taken.

A 1996 DEA sampling of practices employed by schools for the handling of medication indicated that most schools did not have a nurse dispensing medication. Supplies were kept in unlocked desks, and a variety of people, including in one instance a janitor, were tasked with giving medication to the students.

Although most schools have regulations prohibiting students from having their drugs in their possession, many junior and senior high school students carried or administer their own medication.

The extent to which adolescents are abusing methylphenidate is unknown. The following data, however, suggests that although relatively small abuse has increased. The 1999 national high school survey monitoring the future reported that about 3 percent of all seniors in the U.S. Used Ritalin in the previous year without a doctor's order, compared to 1 percent in 1994.

The established emergency room, estimated emergency room mention for methylphenidate increased from 271 in 1990 to 1,727 in 1998. 62 percent of all 1998 emergency room mentions were for kids 6 to 19 years old. A 1998 Indiana survey of 44,232 students, found that nearly 7 percent of Indiana high school students surveyed reported using Ritalin illicitly at least once, and two and a half percent reported using it monthly or more often.

In summary, the data shows that methylphenidate and amphetamines have high abuse potentials, produce effects nearly identical to cocaine, are diverted, trafficked and abused by a wide variety of individuals. Unlike other Schedule II drugs, methylphenidate and amphetamines are primarily prescribed to children.

Information available to DEA indicates that adolescents are using methylphenidate illicitly and that the primary source is from individuals that have been prescribed this drug for ADHD. Probably the single most disturbing trend is that adolescents do not view abuse of this drug as serious.

The DEA continues to urge the proactive effort of many groups, including physicians, parents, school officials, and law enforcement, to evaluate the use of these drugs in their communities. Continued increases in the prescriptions of these drugs without appropriate safeguards to insure medication compliance and accountability can only lead to increased stimulant abuse among U.S. Children.

Thank you, Mr. Chairman, and later I will be happy to answer any questions.

[The statement of Mr. Woodworth follows:]

STATEMENT OF MR. TERRANCE WOODWORTH, DEPUTY DIRECTOR, OFFICE OF DIVERSION CONTROL, DRUG ENFORCEMENT ADMINISTRATION, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, D.C. – SEE APPENDIX F

Chairman Castle. Thank you. We appreciate it. Dr. Diller.

STATEMENT OF DR. LAWRENCE DILLER, BEHAVIORAL PEDIATRICIAN, BEHAVIORAL PEDIATRICS, CHILD AND FAMILY THERAPY, WALNUT CREEK, CALIFORNIA

Dr. Diller. Thank you for inviting me to this important subcommittee hearing. I'm a behavioral pediatrician. I've been in practice for 22 years. I've been prescribing Ritalin for those 22 years. I've evaluated probably over 2,000 children for behavioral and performance problems at home or at school.

Beginning in the 1990s, I began seeing a new ADD candidate. That child was younger than I had seen in the past, might have been a teenager. Now they're even adults. Many more were girls and women. But most importantly, they were much less disabled than the previous cohort of children I had evaluated in the previous decade and a half.

I began wondering if Tom Sawyer or Pippi Longstocking appeared in my office, whether he or she after several visits with me would also leave with a Ritalin prescription. I became uneasy with my role as a physician, and my attempt to address my own ethical professional qualms at the role I was playing in helping these children and their families led me to investigating my situation, my community situation, and ultimately led to my writing the book Running on Ritalin.

Mr. Woodworth has already alluded to the statistics of a 700 percent increase in use of methylphenidate, apparently a nine times increase in the use of amphetamine in our country, and so I'm not going to go over that again, but apparently what was happening in my suburban upper middle-class, middle-class white neighborhood of San Francisco was going on nationwide.

In Running on Ritalin in part tries to examine what's been happening in our country. Some of it's based on data, some of it's speculative and needs confirmation. But basically, I believe that we as a country have accepted the biological basis for behavior more than any other country at this time, and the belief that something is biological, it must be treated with a medication. That belief has become predominate not only in doctors' minds, but in parents' and teachers' minds too. It appears as if American psychiatry, after 50 years of blaming Johnny's mother for all his problems, has come to blaming Johnny's brain for all his problems, and I have a problem with that either/or dichotomy that exists again today.

While chemical imbalance is the parlance talk for this kind of problem, I see this more as a living imbalance, that the demands on children and families have increased while the social supports to them, their families and schools, have decreased, and there are many, many examples. We expect children to learn at a much earlier age. The alphabet and numbers are now taught to children as young as three. We have educational paranoia currently in our country that says if you do not go to a four-year college, you're doomed economically. Not everybody is cut out for the same square educational hole.

We have now increased classroom size, until very recently. There is now a trend to decrease the classroom size. Parents are working harder and longer, and most importantly, until the 1970s, only one parent worked. Now, approximately in about 70 percent of homes, two parents are working, which makes for much longer day care and many more latchkey children.

We have something afoot in our country which I call politically correct parenting, which basically says if you know how to talk to ADD Johnny, you can avoid conflict. My experience says you try talking to ADD Johnny, he's halfway down the street before you have finished your first sentence.

Managed care has only exacerbated the pressures on primary-care doctors to do something and do something quickly, and it's often a pill. The disability education laws that are very important in helping children get the special services are framed in such a way that parents do go to the doctor for the diagnosis. I understand that. How else are they going to get help? Very often along the way, they also get a pill.

To go beyond just our country, we wonder why in Japan and England, for example, only they use one-tenth of the Ritalin that we do. I come to the conclusion that it can't simply be our speeded-up culture. With people, children in Milan, Tokyo, and London have speeded-up cultures too, and they don't use Ritalin the way we do. So I think it's something else.

Now, one thing, we prize independence and spontaneity of thought and action, and at the same time demand conformity at school. And in these other cultures, there's much more expectation of conformity across the board. The other cultures are more accepting of class and talents, and here in our country everyone can become a Bill Gates.

We also believe in something called medical utopia. You come to see me and follow what I say, I can keep you living to 120, and compress all your problems into the last eight weeks of your life. And that's totally bogus.

Finally, I think we are a country whose culture represents the belief that material acquisition will lead to spiritual and emotional contentment more than any other country, and the pursuit of that I believe the performance, enhancers like the stimulants like Ritalin and Adderall, like Prozac, even like Viagra, will be very popular in our country.

I have no doubt that Ritalin works on the short term. After I have explored issues of family and school, and the kid continues to struggle, I will prescribe Ritalin. But I feel to only prescribe Ritalin and not speak up about the social forces I believe are involved in this process, I as a physician become complicit with factors and values that I think are bad for children.

Finally, I will say that Ritalin works at least on the short term, but it is not the moral equivalent to better parenting and schools for our children. That's not blaming parents, not blaming teachers, because they have a very hard job dealing with these kids.

And again, I'm very grateful that the committee has brought these issues that have been bothering me for half a decade to the national attention. Thank you very much.

[The statement of Dr. Diller follows:]

STATEMENT OF DR. LAWRENCE DILLER, BEHAVIORAL PEDIATRICIAN, BEHAVIORAL PEDIATRICS, CHILD AND FAMILY THERAPY, WALNUT CREEK, CALIFORNIA – SEE APPENDIX G

Chairman Castle. Thank you, Dr. Diller. We appreciate that. Mrs. Jorgensen.

STATEMENT OF MRS. FRANCISCA JORGENSEN, SPECIAL EDUCATOR, TAYLOR ELEMENTARY SCHOOL, ARLINGTON COUNTY SCHOOL SYSTEM, ARLINGTON, VIRGINIA

Ms. Jorgensen. Okay. I'm a special educator employed with the Arlington County Schools for the past 12 years, and two years prior to that, at the Lab School of Washington. So altogether, 14 years.

I would like to talk to you a little bit about one of my students this year, whose name is Joe. Joe has been at our school since the first grade. He's with me right now as a fifth grade student. I have worked with him as a committee member because I also rotate position as chair of the special ed committee at our school, and currently Joe is within my fifth grade program.

When Joe initially transferred into our school in the first grade, it was immediately apparent that there was something wrong with our schedule and our routine, that Joe was not able to accommodate his learning, in addition to rotating classrooms and to meeting the routine and guidelines that the other students were able to meet. Our teachers in the first grade monitored Joe very closely throughout that first year, and by the end of the year, Joe had fallen significantly behind his peers.

In second grade, Joe continued to lag behind, and there were problems with getting him to complete assignments. I'd like to paint a little bit of a picture of what we saw in Joe in first grade. He could not concentrate for prolonged periods of time. When I say "prolonged," I do mean five minutes. Five minutes was his maximum productivity level, when the other students at that time were mature enough to move on to maybe a 20-minute span.

Joe needed the teacher's instructions in a one-on-one setting, to restate directions for him. He needed directions to begin assignments. He needed directions to work through assignments. He needed one-on-one help to complete assignments. He needed one-on-one help to turn in assignments. Often Joe didn't submit assignments, either because they were incomplete by the end of the class session or he had missed the cue entirely to deliver them. Often this meant that the teacher had to go on a one-on-one setting to find Joe's assignment, which had been put in the desk, in the chair, in the trash can.

Another problem that Joe faced was transitioning, because he could not shut down from one assignment to start up another. This was very long lull of time where Joe was at a loss as to what was next on his agenda. Daily, though, Joe was plagued by loss, loss of his books, loss of his materials, loss of his assignments, loss of his homework, then generally loss of time.

By the end of second grade, after which time we instituted very frequent contact with his parents, we decided to take Joe to our school student study committee. This is a committee whose job it is to analyze current programming and determine modifications to that program. The recommendation of this student study committee was that we perform a full battery assessment on Joe, including psychological assessment, behavioral, educational, social and medical evaluation.

At this time we instituted several accommodations to Joe's program. We continued to talk very frequently with his parents, who also told us that they saw some of these same behaviors at home. They could not get Joe to complete assignments at home any more than we could at school. We required that Joe maintain an assignment notebook where the teacher would help him record assignments that were to be finished at home. The teachers initialed that assignment, and the parents initialed that they had seen it to completion.

We tried to sit Joe in a location that would maximize his productivity in the classroom. This is a routine that I call the dance of the desks, because we tried the front of the room. That was too stimulating. We tried the back of the room. He had no stimulation. We tried the side of the room. It was too sunny. The other side of the room was too dark. We tried rotating Joe throughout the entire classroom until we found a decent fit.

Because students rotate to different teachers, we did the dance of the desks several times that year for Joe. We tried to lessen his movement, determining that perhaps moving him to another teacher was detrimental. We kept him with one teacher, and then we realized that Joe was totally under-stimulated. He was doing nothing, because he sat in the same chair for much too long. We tried increasing movement opportunities, decreasing movement opportunities, and the balance was very difficult to achieve.

By this time, we had completed the requirements for the eligibility committee to determine whether Joe was a special needs student. What we discovered at the eligibility committee was four things. Joe was academically behind his peers, by this time two to three years. Psychological testing indicated that he had way above average potential. Behavioral testing indicated that his behavioral problems at this point had surpassed his academic concerns. And medical testing showed that he had high behaviors compatible with attention deficit hyperactive disorder.

By this time, we instituted more accommodations to provide Joe some modicum of success. He had a study buddy in each class. He had a second set of books at home. He had a checkout system implemented at school. He had different colored folders and different colored markers. We used disk storage rather than paper storage to lessen the likelihood of lost paper. We helped the parents set up a viable work space at home. We removed the restriction of timed events. He had study guides, small group instruction, personal contracts, and we taught him how to organize himself and we taught him how to take tests appropriately.

At this time Joe's pediatrician recommended to his parents that they try Ritalin. Joe's parent were adamantly opposed to this, thinking that their partnership with the school could overcome some of these deficiencies with Joe. After three years of trying to overcome the deficiencies with Joe, his parents finally committed themselves to trying the Ritalin therapy.

There were several false starts where they started, pulled back, and said, there's got to be something else. When they finally committed to a long-term result time for him, we were able to document some of Joe's successes, which I'd like to share with you.

Joe can attend. He can pay attention. He can transition from one class to the next. He has his materials more often than he's lost them. Most dramatically was the change in Joe's behavior. That he was no longer implicated on playground fights or school bus scuffles. He has learned that, he's started to take pride. He's a fifth grade patrol. He wants to go MIT. Joe is and will be a success. The external controls that we have provided at our school were not enough for Joe. The missing component was a medical, and in this case, the whole is far more than the sum of its parts.

Thank you so much.

[The statement of Ms. Jorgensen follows:]

STATEMENT OF MRS. FRANCISCA JORGENSEN, SPECIAL EDUCATOR, TAYLOR ELEMENTARY SCHOOL, ARLINGTON COUNTY SCHOOL SYSTEM, ARLINGTON, VIRGINIA – SEE APPENDIX H

Chairman Castle. Thank you, Ms. Jorgensen. We appreciate that story. Ms. Robertson?

STATEMENT OF MARY ROBERTSON, BSN, RN, PARENT AND IMMEDIATE PAST PRESIDENT, CHILDREN AND ADULTS WITH ATTENTION DEFICIT/HYPERACTIVITY DISORDER, LEXINGTON, KENTUCKY

Ms. Robertson. Chairman Castle and members of the subcommittee, thank you for the opportunity to appear before you this afternoon. I speak to you as the mother of two children with ADHD, but my testimony represents millions of families who deal on a daily basis with the issues surrounding the diagnosis of ADHD.

Due to time constraints, I'm only going to describe the history of one of my children.

First, it's important for you to know that a diagnosis of ADHD crosses all age, sex, socioeconomic and racial boundaries. Second, it is not the parent who seeks the diagnosis of ADHD. However, the parent seeks help for their child who is struggling to succeed at home, at school, and in the neighborhood. Parents turn to the medical profession for help.

As you will hear from my story, it is not the parent who seeks medication. However, parents seek help for their child who continues to struggle and is failing. It is not the parent who gives up on the child with ADHD. However, all too often it is the schools, the doctors, and society who choose to deny the disorder exists and the devastation the disorder causes when left undiagnosed or untreated.

Now, I knew my son Anthony was destined for greatness. However, his preschool, our neighbors, family and friends sometimes had different opinions. One day the director of his day care called and asked me to pick him up. When I arrived, she requested that he not return; so much for trying to hold a job. I remember the heartache of packing up my son's belongings from his little cubby. Tears streamed down my face. I blamed myself for his inability to behave appropriately.

Unfortunately, Anthony's symptoms worsened. In 1990, Anthony entered the Hyperactivity Clinic at the University of Kentucky Medical Center. After a comprehensive evaluation, at the age of four, Anthony was diagnosed with ADHD. We enrolled in the clinic's parenting classes, but continued to pursue other possibilities to explain his impulsive and hyperactive behavior.

We sought evaluations from a neurologist, from an allergist, then from a hearing specialist. We had his vision checked, made repeated trips to his pediatrician, visited other psychiatrists and psychologists. We tried allergy shots, special diets, behavior management, accommodations and interventions. Nothing seemed to work.

It was around this time that I became aware there were others like Anthony. My pediatrician told me about an organization called CHADD, Children and Adults with

Attention Deficit Disorder. CHADD gave me the knowledge and power to sustain my long-term efforts to manage my son's care. No one else seemed to care.

Two weeks into his kindergarten year, the phone began to ring, just as it had done so many times during the preschool. Anthony had been diagnosed with ADHD during the preschool. His kindergarten teacher knew he had been diagnosed with ADHD, and wondered if he'd ever tried Ritalin. I feared the day that the word "medication" would be used in the same sentence as my son's name, but now, as my son's struggles worsened, after trying everything the professionals told us to try, and if accommodations and interventions and counseling, behavior management and love were not enough, what I came to fear was the possibility of medication not working.

He seemed to always be getting into trouble. He could not stay in his seat, not at home, church, school. His level of energy and movement caused things to spill, fall and break. His frustrations were beyond words. Blocks and chairs were thrown. Occasionally, he would have hysterical temper tantrums that would last for hours. On these occasions I would have to hold him, sitting on the floor with my arms and legs wrapped around him so he could not harm himself. I would rock back and forth as I held him, praying and silently crying until he would give way to exhaustion.

We had delayed a trial of Ritalin for as long as possible. Anthony began to fear and dread school. The few friends he had were beginning to stray. Then one day after he started first grade, he came home in tears. He ran through the door and flew to his bed, and he begged me to help him to be like the other children. He did not like getting into trouble every day. He could not remember how to spell, and he was tired of being sent to the hallway. After I calmed my son, I went to the telephone and called his pediatrician. The next week Anthony started on Ritalin.

The change in his behavior, ability to pay attention and learn is not overstated as I say it was like watching a scene from Dr. Jekyll and Mr. Hyde. The difference was unbelievable, and yet the guilt of turning to medication took years for me to overcome.

While Ritalin seemed like a lifesaver, there were side effects. When the medication was in his system, he was able to pay attention, remain seated, stay focused, make friends, learn to read and write. However, when the medication wore off, all hell would break loose. The medical field calls this reaction rebound. It's a cluster of symptoms experienced when medication wears off. In the case of Ritalin, many children experience rebound. The blood level of the medication drops and their behavior returns with a vengeance.

After a year of trial on Ritalin, we opted to try a different stimulant. The stimulant seemed to work as Ritalin did, but Anthony was not experiencing rebound.

Anthony remained on stimulant medication throughout elementary school. Despite his early rough start, when he attended his fifth grade graduation, he received multiple awards, including one for good citizenship, academic team, academic achievement and outstanding science student award.

In middle school the hormones kicked in, and as often happens during adolescence, the stimulant medication stopped working. Regardless of his prior success, and the fact that his home life remained consistent, and accommodations were being attended to within the school, Anthony began to struggle again. He spent much of his time in the principal's office, and he often missed entire chapters of subjects.

By mid-seventh grade year, his world and our world fell apart. He became clinically depressed. He was removed from school for five weeks and received treatment in a day program for three weeks. Recovery was not easy, but we began the long climb. Different medications were attempted.

Finally, a combination of an antidepressant and a stimulant medication, along with counseling, an individualized education plan and consistent encouragement from his family, he seemed to once again focus and became available for learning.

Next week he graduates from the eighth grade as an honors student. He's starting high school this fall, and he will be taking advanced classes. His goal is to become an aeronautical engineer.

Kids with ADHD can be successful. However, children who are left undiagnosed or treated inadequately will surely struggle and often fail in our society. As a parent of children with ADHD and a member of CHADD, I welcome expanded governmental support for research on ADHD, on the causes and treatment, as well as barriers to receiving adequate diagnosis and treatment.

I urge you to resist any effort to demonize people with ADHD. These children are our children. Do not give into the sensationalism now associated with the name Ritalin. To do so would be a grave injustice to the millions of children and adults who really do have ADHD and want only to succeed in life.

Thank you, and I would be happy to answer any questions.

[The statement of Ms. Robertson follows:]

STATEMENT OF MARY ROBERTSON, BSN, RN, PARENT AND IMMEDIATE PAST PRESIDENT, CHILDREN AND ADULTS WITH ATTENTION DEFICIT/HYPERACTIVITY DISORDER, LEXINGTON, KENTUCKY – SEE APPENDIX I

Chairman Castle. Thank you, Ms. Robertson.

Let me, just before we start questioning, thank all of you for your compelling testimony, both in terms of factual stories and anecdotes about the personal side to it, and frankly, it's a little bit overwhelming in terms of trying to approach and asking questions and getting answers, because of all the different things that you did touch on, but I appreciate your sharing this, particularly the personal stories that we have heard here today.

And also, before we question, if I hear this correctly, I hear in certain instances, Ritalin has worked and has helped a great deal, but there's some serious questions which were raised by overuse of Ritalin, and maybe there's some balance in between that needs to be struck. I don't know. I don't know the answers to this. I'm not an expert on it. But we up here are going to try now to ask you questions.

As I have indicated, we each get five minutes, as well as we need you to give your answer in those five minutes. Perhaps if somebody else is answering, you want to say something, keep it brief, unless some members ask you to respond to a particular question. That way we'll try to develop as much information as we can to help us in dealing with these problems.

I will start the questioning now. One thing I would like to get out of the way, you referred to very early on in the testimony about the lax accounting of medications in school. I assume there is different school policies about the handling of, well, the medication of Ritalin, but other such medications, in terms of how that is done. Is that correct?

Mr. Woodworth. Mr. Chairman, the oversight of schools goes beyond the purview of the Drug Enforcement Administration.

Chairman Castle. Is it strictly a school decision, school-by-school, state by state?

Mr. Woodworth. As far as I know, but I am not sure of the answer.

Chairman Castle. Okay. I am not an expert on what Ritalin is, but, you know, we have heard comparisons that it is similar to cocaine, which I am sure is bothersome to those whose children benefit from it. And you probably, more than anybody here, could help us a little bit with this, or perhaps Dr. Diller could.

Are the two similar in substance? Do they have anywhere near the same effect on the human body? I assume it is not addictive. I am interested in the comparisons or lack of comparison between the two, if you could help with that.

Mr. Woodworth. Yes, sir. I will take a shot at this, and perhaps Dr. Diller can help me out. Scientists, physicians, other practitioners have paradigms that they use to evaluate drugs for animals and humans to determine, or they can do so with a great degree of accuracy, whether those drugs are abusable. For stimulant-type medications, amphetamine is what you might refer to as a prototypic stimulant. It has been around for a long, long time, has a very high abuse potential, and the abuse liability is well established.

In those paradigms, when compared with amphetamine or cocaine, you can make a determination of whether methylphenidate will be abusable. There is over 30 years worth of scientific literature that revealed that that is in fact the case. Under similar dosage forms, by the same or similar route of administration, neither animals nor humans can tell the difference between cocaine, amphetamine, Meth amphetamine or methylphenidate amphetamine.

Chairman Castle. Dr. Diller, I will ask you to comment on that, but I also ask you to add something to that. That is simply this: In your knowledge as a physician, is there sufficient scientific research with respect to Ritalin and its impacts and side effects, et cetera? I mean, in your testimony you indicated that there has been an increased number of people, even before you wrote your book, who came to you in your practice who wanted to use Ritalin, who perhaps did not--I forget your exact words--were not as disabled, and they were younger in some instances than before. In other words, a greater will to get it.

I just wonder what's the science behind this. Anecdotally we hear that it works. I have had many people tell me it works. Others are concerned about it. If you could help with all of these things, I would appreciate it.

Dr. Diller. Let us first go back to the question of abuse. Ritalin is undoubtedly abusable, but whether it is actually abused and by whom is a whole other question. So the incident, both in my practice and in general, of children--paradoxically, they say how can a stimulant calm down a kid, you heard from Mr. Woodworth that it acts the same on everybody. Low doses of stimulants will get anyone to stick with things they find boring and difficult. The only thing paradoxic about Ritalin is it is safer in children than in adults. Why? Because children don't self-medicate, and they don't like the higher doses. Teenagers and adults can do both.

I think the issue gets mixed up very much in terms of children taking this drug. The won't get addicted. They never do really. Practically, I would say never, if I can make that kind of statement.

However, as this medication has been used, increasingly being recommended to be used throughout the life span, there I think we are potentially adding a high volume of a potentially abusable drug to a vulnerable society, and it appears like every 15 or 20 years, American physicians lose their collective memory and find another reason for giving stimulants to adults, and it has happened since World War II about three or four times. Invariably, a small core group of people become addicted.

Now, answering your question in terms of the study of Ritalin, Ritalin is probably the most studied drug outside of some of the antibiotics, and possibly even including the antibiotics, in children. Now, having said that, there are thousands of studies on Ritalin, but of those thousands, perhaps 9,900 are on boys ages six to 13. Of those 9,000 studies or so, all but three cover anything less than 18 months.

Now, you can say how can that be? Until recently, these other populations weren't being studied, so we don't have data on three-year-olds, we don't have much data on girls, we have virtually no data on teenagers and adults. And we have three studies about long-term outcome that up to now have been felt to be flawed on some basis, but those long-term studies on the children who took it ages, let us say six to 12 or 13, are now postadolescents, are fairly disappointing in the value of Ritalin, but also seem to exonerate Ritalin as causing problems in these adults; they continue to have problems.

Chairman Castle. A brief answer, if anybody can answer it. I understand that boys are diagnosed with ADD about four times the rate of girls. Is that generally correct.

Dr. Diller. Studies vary. That would be fair to say, but interestingly in the adult population, they are finding women being diagnosed more than men, and I think that's again reflecting more a social ecological situation involving the diagnosis, not simply one of gender, brain neurology.

Chairman Castle. My time is up, but I do want to ask Ms. Jorgensen one brief question. I very much appreciate and I could have asked either of you. I will ask you, Ms.

Jorgensen.

But in your story of Joe, and clearly I think it would be your conclusion that Ritalin is helpful?

Ms. Jorgensen. Absolutely.

Chairman Castle. I am sure you could have used some other story. You happened to think that was the most depictive of what you wanted to say here today.

Would you say that you have seen that repeated again and again to the fact of 99 or 100 percent, or have you seen other cases in which the use of Ritalin was not as beneficial as it was for Joe, or even situations in which it was not beneficial at all?

I mean, is Joe's situation typical? Is it totally typical, or is it one way it can work?

Ms. Jorgensen. I wouldn't say Joe's story is typical at all. It is a typical success story. I would say we go through all of those external accommodations before we get to the very final result of all the components in place. In that respect, it is typical. But no, Joe's case wouldn't typify every student with ADHD at our school or in all of my experience plus the Lab School.

I would say with some students, Ritalin has had no effect. After we have documented six weeks, six weeks of behavior with this child on the medicine, we have not been able to identify that his behaviors have improved at all.

Chairman Castle. I assume it is a trial and error. There's no test you can give that Ritalin would work. You have to try it, and if it doesn't work, then you go on to something else.

Ms. Jorgensen. Absolutely. We are given guidelines before the beginning of the trial period on typifying behaviors, documenting those for a physician. Once the trial period is in place, then we document the behaviors routinely, and submit those facts to the physician.

Chairman Castle. Dr. Diller, very briefly, then we have to go on.

Dr. Diller. There's a misunderstanding to say a response to Ritalin means the child has ADD, because again, accept if you're very angry or very sad or very anxious, stimulants will probably improve your performance. So typically a doctor will say, let's try it, and if he responds, he must have it. Well, then you will be getting 90 percent of the population.

Ms. Jorgensen. In Joe's case, that actually happened at the end, where we had gone through three years of accommodations before we went that route.

Chairman Castle. Thank you. Ms. Woolsey?

Ms. Woolsey. Thank you, Mr. Chairman.

Thank you for your wonderful testimony, all of you. When I talked about Ritalin and my fury, it has nothing to do with the children you two are talking about. I believe there is a whole group of kids--I am a mother of four, and three boys and a girl. My youngest child is 33 years old. But I am telling you that these were the kids that now are being put on Ritalin, just because they had mothers like me that never sit down. I mean, I was hyperactive, they were hyperactive. I mean, they have energy, and they're just the most successful adults, but I think those are the same kids that we are pegging into Ritalin prescriptions now. Not the kids that need it, because for whatever reason is causing, you know, the other parts of it.

So what I want you to do, if you will, is talk to me about how we are going to get parents, teachers, society, to pay attention and time to these children, so that they just learn to live and change the behavior and become good adults without being medicated. So that is a broad question. But that is my question.

I am so afraid of what we are doing to our children because we do not have time to work with them. Our children that do not need it, truly need it.

Doctor, why do not you start?

Dr. Diller. There is a core group of children and adults even, I think, you do not really need an M.D. To say there is something terribly wrong here. They often have other problems besides simply impulsivity and hyperactivity, and that is not the group we are talking about. That is probably a pre-1990s group.

I think the notion of getting parents to spend more time with their kids or feeling more comfortable in the medium form of discipline are great societal issues and questions.

Now, I can say for this group of Tom Sawyers and Pippi Longstockings, when I talk to them as teenagers, or even talk to their parents and their younger children, I say, life after high school gets better. There are many, many more occupational niches for you than this notion of performing at a desk for six hours. I am exaggerating a little bit.

So I think this current crop of ADD/Ritalin kids, at least that are appearing in the primary-care doctor's office, is another kind of kid than the child you talked about. And I think the prognosis for those children are much more hopeful, but in the meantime, getting parents to feel more comfortable that not every child is that square peg is very, very difficult, because they're anxious and they love their kids, and again, I want to say that I don't know a single parent who with glee is medicating their child, and they only do this with great reluctance.

Ms. Woolsey. Could I ask a question. I was always under the impression that when Ritalin was necessary and the child was diagnosed as needing it, it did not affect that child the same way it would a child that was taking it that did not need it. And that by the time a child was a teenager, Ritalin virtually becomes speed.

Dr. Diller. The best studies on the effects of methylphenidate, it is actually the effects of amphetamine. Again, as Mr. Woodworth has indicated, amphetamine and Ritalin in large cohorts of children operate identically, both in terms of their effect and side effect.

The best studies on the effects of Dexedrine on normal children came out of the NIMH in the 1970s, where they first gave it to normal adults and saw their performance improve. And then on an ethical basis, they struggled with finding normal children to give it to, and they decided that they would pick their own children and their colleagues' children.

And indeed, on tests of performance that required increased concentration, both the ADD identified groups and the normal children improved. The normal children started here, in terms of their performance, and the hyperactivity children started here, and when they were given Dexedrine, the performance moved up like this.

So, in a sense, it leveled the playing field for the ADD kids, but it enhanced the performance of the normal kids, which is a major issue, by the way, in my practice, and I am often questioning, am I treating a disorder or enhancing performance of a high school student who has Ph.D. Parents? Again, I am creating a caricature here. This is not such an easy call here at times, where the child is getting Bs and Cs, and there is a sense of a potential, but he is not particularly motivated at this time. And many of the characteristics of his behavior fit the DSM, Diagnostic and Statistical Manual of psychiatric disorders, criteria for ADD, inattentive type. You do not have to have the hyperactivity. And I get into an ambiguous situation there. It is a difficult call for a guy who prescribes a lot of Ritalin.

Ms. Woolsey. Can I ask another question?

There is a cause, parents wanting their children to excel, not being satisfied with a B or a C child. But what is the cause of the increase in the need for Ritalin? Is there some truth in the fact that so many young parents now use drugs and alcohol so early in their own lives, that it's carrying on to their children's lives? Why is there so much of it?

Ms. Robertson. I think part of it is we are recognizing adults now too with ADHD, so that there, the increase in Ritalin too would be associated somewhat to the effect of adults being prescribed the medications.

But I also think it has to do with the recognition now. There's a lot more recognition of ADHD, and that has pros and cons with it. The problem is people see it as a behavior issue, and so as soon as a child is misbehaving for any long period of time, the first thought is ADHD. But it could be any number of things.

And interestingly, I had a conversation last week with a middle school principal, and I asked him, I said, "What's your feeling about what the media say, that teachers are pushing us," and he said, "Well, it is interesting, because when the teachers do all that they can, like for this child, and when nothing works, then they say, you need to evaluate this child, and they suspect ADHD." .

And then the principal says, "When 100 percent of the time that the referral comes back as yes, it is ADHD, the teachers start thinking, well, they're doing the right thing, because they were referring it out." .

It is always coming back, when in fact if there's not a thorough evaluation, it could be any number of issues going on and not necessarily ADHD.

Ms. Jorgensen. May I submit another thought on that, please. There is another federal guideline for a route where we can identify students with behavior problems. They are not all identified ADHD, not in my school, not in my county, not in the state of Virginia. Several students are identified emotionally disabled. And that is another viable route. So please do not leave here thinking that every child who misbehaves at our school is labeled ADHD and is then put on Ritalin.

I do believe there are many other routes we travel before we walk that road.

Ms. Woolsey. I trust that you do. But I trust that too many do not.

Ms. Jorgensen. Yes. Thank you.

Chairman Castle. Thank you, Ms. Woolsey.

Mr. Goodling. Since I've been in Congress, I've been trying to lead a charge to make sure that we come up with our 40 percent of excess costs spending as far as special education is concerned, but every time I lead that charge, I also remind them that if we can not stop over-identification in special education, there is no way under the sun we'll ever get the 40 percent. There is not enough money in the world to do that.

I have a feeling, after listening to both Mrs. Jorgensen's testimony and Ms. Robertson's testimony, that we may have the same problem here, and our problem that I guess we have to deal with then is the over-identification problem.

Because although I don't have the statistics to prove this, I have a feeling that there may be five youngsters who did not go through the process that both you as a parent and you as a special ed teacher went through with children in relationship to alternative opportunities before the diagnosis was made and before the medication was part of the routine.

So it would appear to me that we may have the same kind of over-identification problem here that we have in special education.

I don't have any specific questions. I was going to refer to you, Doctor, so, when I refer to you, you can also respond. I have watched Bobby Knight for 20 some years, and I know that there is no way under the sun that he can ever modify his behavior to do what is now expected of him, and I am going to write to him, tell him that.

I was going to ask whether it is all right if I suggest that he might contact you, because he is going to need help.

Dr. Diller. Does he need Ritalin or Prozac? That is the question.

Mr. Goodling. You wanted to respond.

Dr. Diller. Well, just that there is the way our disability laws are based on the civil rights laws, and they started with the position initially for the blind and the deaf, in terms of special education, and they have grown and grown and grown, the idea that services be based on a diagnosis is a real problem here. And what it does is lead people to seek diagnoses, again, not in some kind of manipulative fashion, but sort of a legitimate desire to get help for their child in the school.

And what you get is this real bind between the needs of the community versus the needs of the individual. As you know, as more and more people seek to get a disability label for their child and get funds diverted to the special education programs, it ultimately drains the general education fund. And we have a phenomenon where those borderline symptomatic children in the ever-increasing larger general education classroom become symptomatic and then seek services to address their symptoms.

And I think the ultimate solutions are not the one of pulling these kids out, but having the special ed people right in the classroom, the use of a paraprofessional to help all these children, but to target some of them, and this is really radical, moving away from a diagnosis-based system.

They already do that in dealing with mental retardation. It is called a needs-based system. You decide what the kid needs rather than what a kid has, then you get around all of these how many angels dance on head of pin, if you have ADD or oppositional defiant disorder, or does he have learning disorders. Virtually none of these psychiatric disorders have any kind of rigorous testing that you can define, and they put an enormous pressure on the physician to come up with the right diagnosis, to get the services for the child.

Chairman Castle. Thank you, Mr. Goodling. Mr. Kildee.

Mr. Kildee. Thank you. Let me ask Dr. Diller this question: Is there anything close to an objective diagnosis of ADD or ADHD and that Ritalin can be helpful? Ritalin is a chemical that is introduced to the body. Is there anything close to where we have a diagnosis to determine whether it is an deficiency that requires this chemical to be injected into the body?

I ask, in going through another area because I do not think there is that much difference between mental health and physical health. Sometimes you make those divisions legally. But with diabetics, we realize there is a need for insulin. Are we anywhere close to a diagnosis, or is that research being done in that area?

Dr. Diller. There is much research. That is where all the research is happening, trying to get a biological correlate to this kind of behavior, and it's very, very difficult, because the condition as even listed in the, again, DSM, actually is probably very heterogeneous, meaning many, many different things contribute to this kind of behavior. So, the guys who are doing the brain scans complain, "Can't you get us the same group of kids to study so we can get one finding here?" .

So, up till now, there is no single abnormality that has been consistently identified with the kids who get called ADD. Now, I want to be clear here. Because there's one thing that is going to upset Mary, is this notion that having said that, someone's going to say, well, you see, ADD does not exist. And that really upsets parents who have struggled with this and teachers who have struggled with this.

That there are children who seem very much driven by their neurology, in terms of being impulsive and hyperactive and maybe inattentive, there is no doubt. But how do we identify those children? The guidelines set out by the American Psychiatric Association, and the American Academy of Pediatricians recently set out a system as an attempt to standardize diagnosis. And indeed, it is likely that two child psychiatrists seeing the same child can probably agree most of the time. But the variations in diagnosis from community to community is astounding, and the use of Ritalin, as Mr. Woodworth would show you, is astounding.

There are certain areas in which there is virtually no medication, and there are other areas, in Southeast Virginia, where one in five boys is taking Ritalin at school. And I don't think guidelines from APA and AAP are going to change doctors' practices that much. It is publicity like this, and dollars.

Mr. Kildee. The Ritalin does something to the neurological system, obviously. It does something.

Dr. Diller. It seems to, if you really want to know, dump a lot of dopamine between the synopses.

Mr. Kildee. That was what I was going to ask, if it does something. The body does produce something that it does, something similar to those who do not have that condition then? Right?

Dr. Diller. I think I know where you're going with this. Can there be other ways of getting dopamine to get outside the synopses besides getting Ritalin? Is that it?

Mr. Kildee. Yeah. With insulin and diabetics it's much easier, but there seems to me, there is something that is not acting right in that neurological system, and Ritalin seems to do something for some people. I just wonder whether there is something.

Dr. Diller. The insulin/diabetic metaphor is used with regards to ADHD, insulin for the brain and such like that.

But what you forget is these are biopsychosocial problems, even adult-onset diabetes or hypertension, which are clearly physical problems which respond to medication, the first recommendation from the physician is change your lifestyle, get exercise, diet.

And it is again, I am not against using medication here with these children. But when the doctor, after 15 or 20 minutes, reaches for the Rx pad, and you know what? I will tell you the mother gets really angry when they are doing that, so that is good, but the pressure on the physician is immense to do something quickly.

Coming back to your issue, though, there are wonderful brain scans, not so much in ADD, but in other conditions, called OCD, obsessive-compulsive disorder, and what they did was they divided these two very similar groups of patients. One group got medication, and one group got desensitization training. That is where you get more and more exposed to the thing that makes you anxious. The brain was scanned of each of them in the beginning and showed that the sides of their heads were just lit up with overactivity, the size of their brains. They sent them out on medication, they sent them on behavioral training. Both groups clinically improved and, lo and behold, when you look at their brain scans, both groups showed improvement in terms of the quieting of those systems.

So, your notion that are there other ways of affecting the chemicals in your brain, besides giving someone a chemical, I think you're right on, and I would say, again, it is not that it really does not work, but I don't see it as a moral equivalent.

Mr. Kildee. Thank you, Doctor.

Chairman Castle. Thank you, Mr. Kildee. Mrs. Roukema.

Mrs. Roukema. Excuse me. I thought Mr. Schaffer was going to be the next person. Mr. Schaffer and I are the cosponsors of the resolution that has directed some of our attention to this particular subject today. And I have to say that I am more than a little confused by what we have heard thus far. So let me focus, because I had understood, and here I would ask Mr. Woodworth as well to comment, because we heard his testimony, but he has not interjected himself. He has been so polite.

But in all these aspects, it is my understanding that one of the reasons we sponsored this resolution was two or threefold. One, that this has been evidently, and there was some reference to the fact that now two- to four-year-olds are being heavily dosed with Ritalin or other drugs, but specifically the Ritalin. And large questions arose in that regard.

Secondly, at least, we wondered about the fact that the stories that we were hearing, and I think Mr. Woodward in one form or another in his testimony, although he did not say it specifically, has indicated that maybe, yeah, maybe the schools have become very careless or demanding in terms of what they are demanding of parents and doctors, in order to keep these kids in school, and as a result, they are not looking at any of the needs for mental health services and appropriate services of that order in the school system, but are demanding, as a way of getting the kids back in class, that they get some kind of treatment.

So kids are becoming, in quotes, addicted to Ritalin, rather than having what I think Dr. Diller referred to, but he did not seem to stick with the issue, and that I am sorry I am challenging you, that Ritalin is prescribed for short term, but it works in the short term, but it does not apply as a substitute for good parenting, or I would say maybe at the same time good therapy of another sort that may be in order for these children.

And when you go on from there, it is just a wonder as to whether or not we are not just creating other kinds of problems, long-term problems, rather than solving things in the short term.

I just do not know whether or not you have addressed yourselves to the questions as we understood them. We do not deny--and now I will identify myself, all right, as the wife of not only a doctor, but a psychiatrist, okay? But we are not denying the validity or the usefulness of Ritalin. But we are concerned about the abuses, and the fact that nobody is really thinking about the psychiatric component to this, and I guess there was a reference made that there are guidelines that the APA has presented, and yet we have no one here from the APA. Maybe it will be in a subsequent hearing, but it seems to me that psychiatrists or psychologists or school personnel that are psychiatrically trained should be commenting on these subjects.

I have talked too long, but does Mr. Woodworth or Dr. Diller or one of the mothers here want to comment first? Seems to me that you haven't addressed the problem as I understood it was presented to us originally.

Mr. Woodworth. May I?

With regard to your first comment about prescriptions for young kids, two to four, that's certainly alarming. In my personal opinion, prescriptions, as I mentioned, 4,000, for kids under the age of two has to be quite disturbing, because your brain is still forming at that age.

With regard to your comment about schools.

Mrs. Roukema. Excuse me, Mr. Woodworth. Who is prescribing these drugs? Are they pediatricians or family doctors or psychiatrists, in general? If you do not have it here, can you present it for the record at a later time, if you don't have that documentation here.

Mr. Woodworth. I do have it, if I can lay my hands on it.

Dr. Diller. Seventy percent of stimulants generally are prescribed by primary-care doctors. I cannot give the data on who prescribes it for the two, three, or four-year olds.

Mrs. Roukema. Particularly for young children, but across the board, you are saying?

Dr. Diller. Yeah.

Mrs. Roukema. All right. Thank you.

Mr. Woodworth. In 1998 we showed that 55 percent of pediatricians wrote prescriptions for ADHD, 28 percent from psychiatry, 6 percent neurology, 4 percent osteopathic and 1 percent general practice, which is a little bit different, and then ADD prescribing, pediatricians, 50 percent; psychiatrists, 25; family practice, 9 percent; neurology, 7; osteopathic medicine, 4, and internal medicine, one and a half percent.

Your question is quite good, though, because this is a psychiatric disorder, and one would question who is able to complete an effective diagnosis.

Mrs. Roukema. Can you amplify? I do want to get to you, Dr. Diller, but amplify, Mr. Woodworth, your statement regarding lax handling at schools and that supplies have been stolen, et cetera. Are they also giving out Ritalin? There seems to be some question as to whether or not the schools were dispensing it.

Mr. Woodworth. I need to give you a little bit of background before I answer your question.

The DEA deals with registered handlers, doctors, pharmacies, manufacturers and distributors. We have very strict security and record keeping requirements to monitor the flow of dangerous drugs like methylphenidate through the system, including requiring manufacturers and distributors to store these drugs in safes and vaults. We track this drug, these drugs, until they get to the last point before they are given to you and I as patients, by way of a prescription.

We do not have an oversight over schools, where large quantities of this drug are stored, and they are stored in very insecure manners, in desk drawers, as I mentioned. A lot of schools do not have trained nurses that hand out the medication. So, it is an area where we are very concerned, because it has the least safeguards, and it is the greatest availability in that setting with children who are very young, with the least amount of experience and whatnot.

So, it is of a concern to us.

Mrs. Roukema. Dr. Diller, and then Ms. Jorgensen.

Dr. Diller. Statistics on who actually is prescribing medication may ultimately belie the notion that it is a psychiatric disorder and should a psychiatrist do it. The truth is there are just too few specialists in the area, and it falls to the primary-care doctor, which then also means a lot of inadequate evaluation. Not blaming the doctor here. He is pressed tremendously financially to get things done quickly.

On the other hand, if you go at this point to a specialist like, well, not me per se, I am described as thoughtful in my medication use, but pretty much what has happened is the M.D. Specialist who used to be considered the ultimate expert in a wide range of interventions for children, the child psychiatrist, developmental behavior pediatricians, now if you refer to them, pretty much you can be certain that you are going to get a prescription.

And that has changed, both in the training of psychiatrists and also in the way they are being handled by managed care. Are you tracking that?

Mrs. Roukema. I understand that through my husband's own experience, and you are absolutely correct there, but my question is more to the effect of whether or not we have been misinformed, that the parents and the schools are forcing the parents to plead with the doctors at whatever level. That they have to have this kind of a treatment, otherwise the child will not be permitted back in school.

Has that any validity to it, from your experience?

Chairman Castle. Why don't we have Dr. Diller answer that? I think Ms. Jorgensen still wanted to comment.

Go ahead. Go ahead and answer that drug question.

Dr. Diller. There are anecdotal outlying situations that get the attention of Congressional hearings and media, and I have had experiences, yes, where there is an extraordinary amount of pressure placed on the families to use medication, even in the public setting. One could see for sure in a private setting, where a private school could say what they want.

I would say in general, there has been a shift over the 20 years or so of my practice. In the mid-'70s, really I found myself much more trying to convince the family that it was a reasonable thing to try medication and a teacher. This was coming off very negative publicity in the early '70s.

By the 1990s, more of the time I am asking parents to slow down, especially in the younger children, the three, four, five age group, where there is so much that can be done behaviorally, primarily by working with the parents and the preschool, not by seeing the child by himself.

Chairman Castle. Ms. Jorgensen.

Ms. Jorgensen. I really am feeling the need to give you a little bit of a clearer picture of what I see happening with Ritalin storage and Tylenol storage, even, at the schools.

I have never been in a school where a child has been able to bring in the medicines. The parent really brings in the medicine directly from having filled the prescription, reports it to the school nurse, who then locks it up in a safe cabinet.

I really would rather you not leave this hearing thinking I have stored Ritalin in my desk or any other teacher I have worked with. Nor have I ever administered Ritalin, nor has that happened with any other teacher I have ever worked with.

It truly is a system that is outside of what I do with kids, which is teach and manage an in-class opportunity for them. The whole Ritalin ingestion aspect happens outside of my realm of working with the child, and I really think that is more typical. I have not ever seen a teacher administer medicines to a child.

And I also would like to respond to the notion that parents, or teachers are telling parents, "Go fix your child, I will work with him tomorrow." I really do not think that happens in our school.

I think we should leave this hearing with much more faith in what is actually happening in our schools, which is that there is an awful lot of very hard work going on every single day in our schools where teachers do accommodate learning styles and bring compatible learning differences and all kinds of other things that come our way, where we are working extremely hard with these kids. And not feel like it is typical that we are telling kids and their parents to go get medical help.

Mrs. Roukema. Thank you.

Chairman Castle. Thank you. Mr. Payne.

Mr. Payne. Thank you very much. Those questions are interesting. I didn't know my time had come.

You know, I think that this is a very--first of all, I commend the chairman for calling a hearing of this nature, because it is certainly something that is disturbing as a trend as we see the use of illicit drugs in adults, the high demand for substances which seems to be growing.

This whole question of this deficit disorder, and I think it needs to be really aired, and it is very clear there is evidently no real concrete best way, so to speak. I just know I taught for about 10 or 15 years half time in elementary, half time in secondary school.

During the time I taught, not one single child had any kind of disorder or drug. Now, it was when Abe Lincoln was around. It was a long time ago.

I don't know whether the children today then are so--when we look at the numbers of what we are seeing, and just looking at some of the reports about the increase, some say that, one article here in November, there has been a tripling in the use of Ritalin, and another article in March, there has been a doubling, but there has been a quadrupling use of tricyclics and a doubling of some other antidepressant.

I am just wondering, like I said, that--and I think one of the things we're finding out is that it is difficult to get to what the truth is, so to speak, because I think we are going to find that people become defensive about what's happening. Evidently it works and makes children more calm.

Of course, what I think we are hearing is that is it necessary for as many children that it is being prescribed for, and the question is, does it come from the parent, is it suggested from the school, does it come from a physician? It just seems to me to be abnormal that there has been such a tremendous increase.

Now, we have heard talk also about using medication that is really necessary. We have heard one example, and I think that epilepsy, for example, is really a physical thing, and Dilantin, phenobarbital tends to prevent the epileptic type seizure, but I am wondering whether each of--and maybe some of you all can respond--these children that are given this medication, is it because they really have this need? And I guess all you are saying, it varies, and everyone here does it right, but is it just the easier way to go?

Years ago, you used to treat mental illness by locking up a door and letting people stay somewhere locked up, and they were out of sight and no one ever bothered with them. So, I am just really trying to--because it is so disturbing to see this tremendous increase.

And then secondly, is there any kind of prototype community that this quantum leap and this is occurring? Anyone could try to answer that.

Dr. Diller. The answer to the question is Ritalin overprescribed or underprescribed is yes, depending on the community you assess, your threshold for the symptoms and for using medication versus theirs. So, it varies very, very widely.

What I would get at, there are factors other than neurological ones contributing to the use of the medication. There is a nationwide trend to see these problems as biological, and to use medication on a much sooner basis.

I think if we get toward the end of this, we should be focusing our research, particularly in this three- to five-year-old age group, not so much on how many symptoms do they have to have to constitute diagnosis, and how many pills that they receive in order to improve their symptoms, but more what is the ecology of children receiving this diagnosis and the medication? In other words, what are their families like? What is their school like? How are their schools developing programs to address these children's needs? Does the medication help beyond the short term or the long term?

But simply looking at the child alone and trying to assess his brain by counting symptoms and then counting pills has been the nature of the research of late, or getting a brain scan. And I think that is leaving a lot of us very uneasy.

Ms. Robertson. To address that, I think it's hard, because from a parent's perspective, and dealing with a lot of parents and working with it in schools, I don't see parents coming forward and asking for this kind of help. Unless their kids are struggling, they're not going to be in there asking for a diagnosis of such, and I don't see educators pushing it.

Mr. Payne. Do you thing there is a change in parenting? Even in adults we see the use of, I guess, some kind of--what was that thing I was talking about earlier? Like Valium, for example. I mean, you know, 25, 30 years ago, if you had a headache you took aspirin or Anacin. Today it is seems like this Valium business is kind of--people kind of use it a lot.

Is it that today problems are so much greater, that there are that many people, and I see that this sort of Valium concept almost sort of going down to, stair stepping down, that everyone needs some kind crutch, some kind of help, some kind of thing just to get them through the day.

Dr. Diller. One in ten Americans has used Prozac or a Prozac-like drug, and that does not include even the tranquilizers that you are talking about.

But what has happened here is the issue of using medication has shifted down to our children now. Adults have been now using the Prozac like that for ten years. And I think the ethical burden and the proof that this is useful is much higher in the use of children. It does extend backward, as you said, to the adults. All the adults are taking medication now, too. What does that mean about our culture and society?

But when we are talking about children, people get hot. And I think that is why we are having the meeting on Ritalin, not on Prozac today, too. Because I think the ethical questions raised in terms of nature versus nurture, which apply as much to adults in some ways, for people who are growing and do not make the decisions themselves, raises the level of the intensity.

Your questions, I think, are very reasonable.

Mr. Payne. Are you going to do Prozac?

Chairman Castle. Would you yield to me for a minute. Before we go there to Mr. Schaffer, based on something that Mr. Payne asked, and the answers, which it seems were a little further than I expected, just looking at the statistics which I have looked at, which states here--if you want to question the statistics, that's fine--it says here, "Over the past decade, 1990 to 2000, production of Ritalin has increased to under 2,000 kilograms annually to over 14,000 kilograms annually." .

That is an increase of seven-fold in ten years.

"In 1991, over 3 million prescriptions for Ritalin were written. I am sorry. There's a misprint here. "Over 3 million prescriptions for Ritalin were written. By 1998 over 11 million such prescriptions are written in three and a half times."

That is a huge increase in a period of time, and yet there is sort of anecdotal testimony that nobody seems to be pushing more for it or whatever. Dr. Diller, you did reference the fact that more people seem to be coming to see you with idea of this getting to this sooner at a younger age.

Am I missing something here? It seems to me there has been a huge increase in the use of Ritalin in this country. And obviously if you compare it to other countries where there is virtually no usage, Americans use is overwhelming, as I said up here. Either we're overutilizing or they're underutilizing. Something does not seem quite right to me in all of this.

Dr. Diller. There are people in the scientific profession who will say this is simply medication catching up with need, that this condition has been underdiagnosed for decades. And, you know, child psychiatry is finally catching up to adult psychiatry in its sophistication and its use of medications in very young children, and the notion that you could, for example, medicate three- and four-year-olds, and somehow prevent a lifetime of antisocial behavior is currently at the forefront of child psychiatry, without much evidence, by the way.

So, I think it depends on your point of view. I think the general public tends to be very uneasy for the reasons that Mr. Payne raised. And I as a physician, I call myself a radical moderate, I prescribe medication, but I am also uneasy, and I don't think there is a single answer. I think this is what you're going to find here today.

But I think we should keep on asking these questions, and in the process, we will get decent evaluations, and you know, there will be additional treatments offered besides taking a pill.

Mr. Payne. Let me just say, there isn't any answer. One of the things that is very, very clear is that the escalating use of substances in this nation is extremely dangerous, and it has to be looked at very carefully. The question that we maybe underdiagnosed before and therefore, because it is a quantum leap, this fourfold increase means that we just did a poor job before, now we are doing an adequate job, I think that is a comment.

Parenting is probably--people do not do what they used to do as parents, and this is a substitute, but whatever it is, and like I said, I am the last here to, you know, poke--I have a hard time getting my annual physical. I am not trying to play doctor or statistician. All I know is that there is an awful tremendous frightening to me increase in the use of substances, and as a nation, it is in my opinion, it is very dangerous.

Chairman Castle. Before we go to Mr. Schaffer, I just want to say, in closing on that particular portion, I do not doubt for a moment that Ritalin is helping a number of individuals and should help a number of individuals. But when I see increases along the levels of those numbers over ten years, I have to believe that there is some greater sociological drive here in terms of the combination of what people are exposed to, request of parents, how doctors look at this in a variety of people, and I think that is really the heart of what this hearing is all about.

I am not sure we should legislate about it, but think it's a legitimate question to be raised, to recognize the fact that this does a lot of good.

With that, let me yield to a gentleman who's waited very patiently throughout this whole hearing. Mr. Schaffer.

Mr. Schaffer. Let me start with Dr. Diller, and I am curious about some of the initial comments raised by the chairman as to a comparison between Ritalin and cocaine. And the comment I have heard several times is that the drug Ritalin seems to--that it works. That term is one I want to explore a little further.

I have had a physician in my community, I was just asking some general, rudimentary questions, as a normal parent would, about this same question, one of the comments this physician made to me is, he said, "Well, cocaine would work in many cases," and I would like you to comment on that too.

If Ritalin is good in many cases because it works, as my physician I consulted with, comment on his statement to me that in many cases, prescribing cocaine to some of the patients that receive Ritalin would also work.

Dr. Diller. You know, again, this comes up to the problem of Ritalin as a drug of abuse versus low-dose stimulants used properly. And I think those people who would like to scare everybody from a sensible use of a performance-enhancing drug will invoke the abuse specter of Ritalin and its relationship to cocaine.

That is not answering your question. Having written this, going up against a lot of people who might be angry on either side of the ledger of Ritalin as God's gift, and Ritalin as a devil's drug, I'm not aware of cocaine being--maybe Mr. Woodworth or someone in the audience would know--cocaine being looked at specifically as a focusing agent. Anecdotally, I have several reports from unmentioned people who said they would use cocaine in low doses to do work, and so I would not be surprised on any basis if it was taken in a minimal fashion, that cocaine probably would have slightly more euphoric effects, in my opinion, than methylphenidate.

In a similar way, caffeine, as a similar structure, as a similar drug, was looked at quite closely in the 1950's as a focusing agent, and what it tended to be is that in order to get the level of focusing that you could get from amphetamine or Ritalin, you would have unacceptable cardiovascular, head throbbing, heart pounding kinds of side effects with caffeine.

With cocaine, I suspect you will get too much euphoria.

Mr. Schaffer. As far as the addiction, we talked mainly about Ritalin today, but there are several other drugs that are prescribed in cases of ADD or ADHD, Zoloft. Are there any other drugs that are prescribed in these cases that could be addictive?

Dr. Diller. That could be addictive? By the way, Mr. Woodworth may want to comment on this. It turns out that even the stimulants, while creating a terrible craving, do not create the same exact kind of physiological addiction that we might think of in terms of alcohol or in terms of Valium or other narcotics.

So, you know, there are mild withdrawal symptoms, when you use tricyclic antidepressants. Some of the anticonvulsants that are now used in psychiatric problems have associated mild headache, stomachache, dysphoria type of feelings when you take them off. Clonidine you can't take yourself suddenly off because your blood pressure may rebound. And again, we are using Clonidine increasingly for problems of ADHD.

Mr. Schaffer. I would like you to comment, if you would, Mr. Woodworth, on an article from October 16, 1997, in Investors Business Daily, an article by John Murlowe, and he makes a couple of comments based on it is research he did for this article, "Data Suggests a Link Between Money and Ritalin Use."

There's a statement, "The Department of Education might have played a role in the rapid rise in Ritalin use." It goes back to the date or the year you cited here in your testimony, I think, 1991. It says that in 1991, the Education Department said schools could get hundreds of dollars in special education grant money each year for every ADD kid diagnosed.

I am curious as to whether your agency has also evaluated the co-relation between connecting cash to the diagnosis and prescription.

Mr. Woodworth. Yes, sir.

Mr. Schaffer. And the increased diagnosis. I should say that.

Mr. Woodworth. It was not part of my testimony with regard to the second part, educational institutions, and I do not nor does the DEA have any information with regard to that part.

A number of years ago, it came to our attention that the pharmaceutical company had made contributions to the advocacy group in different ways, and we revealed that, and as a result of that, we had a number of meetings with the pharmaceutical company and with the advocacy group CHADD, and it was under, I might add, previous leadership, and I believe that that issue was addressed, solved and stopped at the time.

Mr. Schaffer. That is the basis of the Texas lawsuit. That is asserted in the Texas lawsuit.

Mr. Woodworth. I don't know the answer to that.

Mr. Schaffer. Ms. Robertson, since your organization came up, could you clarify for the committee, does your organization receive funds from the community?

Ms. Robertson. Yes. Actually, we are nonprofit, so the majority of our money comes from membership. However, it is also, the organization and the diagnosis itself is not one that is real popular among people who want to donate money. They want to donate to the heart association, et cetera, so getting funds is a little more difficult than, say, other nonprofit organizations that work for kids.

However, when we do accept pharmaceutical money, it is accepted and a contract is signed which says in no way will they have anything to do with, any say with how the organization runs or the projects. And CHADD solely directs the projects of the organization. Money does not, nor does another, nor does the pharmaceutical industry.

But I did want to go back and address your question about the diagnosis and the money coming in. A diagnosis of ADHD does not assure funding in a school. The only thing that would increase funding to that school would be if that child was placed under special education, which in all of my experience is very difficult to get. It is not given to any family easily. It is a long process.

So, you know, it is not an automatic, that you have ADHD, you're getting to get additional funds.

Mr. Schaffer. I didn't have a chance to go through the whole article, it talks about SSI as well as IDEA funds, as well as some welfare, food stamps eligibility as well. So that combination of cash availability.

Dr. Diller. If you look at Ritalin production at least, and I think that may be one of the more accurate Ritalin production prescriptions, you look at a track date the 1980s, it states fairly stable. In 1991, it begins an abrupt rise, to increase by 700 percent over the rest of the decade.

One looks for a reason why 1991, and I and others have come to a conclusion that there was a whole host of socially combustible material out there, and the match that set this off was the change of IDEA. I'm not blaming parents for trying to seek help for their children, finding out one of the avenues for getting help for their children might be an ADD diagnosis. Then the media and the word spread, and I can't come up with another reason why 1991 is the year.

Chairman Castle. Let me just raise that question. Who actually makes Ritalin? Is it one drug manufacture under patent, or is it generically made now? Does anybody know where it comes from, and have they done anything to try to increase the use of it, to your knowledge?

Mr. Woodworth. The generic substance is called methylphenidate, and there are a number of bulk manufacturers and dosage form manufacturers of the generic substance. The trade name Ritalin is made by Ciba-Geigy, now called Novartis. It was taken over by Novartis.

Chairman Castle. And my next, the follow-up question was, have they done anything to try to engender greater sales or usage of this in the physician community, for example, or in any nonprofit organization, or anything else we know about?

Mr. Woodworth. In my--

Chairman Castle. I'm not suggesting or implying they have. I just mean, the question has led me to think that it is a possibility.

Mr. Woodworth. A number of years ago, we were concerned, the DEA was concerned that that might be the case, particularly as concerns promotion and advertising, because this is a psychotropic substance, the United States is a member of, a party, a signatory to the Psychotropic Convention, so there is certain obligations on United States in complying with that. Article 10 of the Psychotropic Convention prohibits advertising or promotion of controlled substances, psychotropic substances, directly to the public.

So we were concerned of the role of the pharmaceutical companies in that regard. We did have a number of meetings, as I mentioned, with the pharmaceutical company and CHADD in order to address that issue.

Dr. Diller. As a physician, I would say my experience has been varied. Actually, the makers of Ritalin I think in general have behaved fairly responsibly in promoting a very much multimodal evaluation and Ritalin as part of a treatment model.

On the other hand, reflecting the huge increase in the last three or four years in the amount of amphetamine being produced in this country, is directly reflective, I believe, and I think you would agree, of one single company's marketing skills of this product to physicians. And that is a triumph for American advertising, that you can say that Adderall has actually surpassed trade Ritalin prescriptions in the last year and a half, and where Ritalin has somewhat stabilized.

So, does advertising have an effect? It is supposedly a new choice for physicians to offer their children, but we have had Dexedrine for 40, 50 years, and whether or not Adderall is really any real improvement over Dexedrine, except for its advertising, is very, very questionable.

Ms. Jorgensen. May I add a thought on the correlation between the time of the increase in Ritalin prescriptions and the time of IDEA legislation?

IDEA 1991 is what you have stated may have been the cause for this increase. But at that time, if a child was diagnosed with attention deficit hyperactive disorder, there was no federal legislation for that child being a special needs student. We were not able to do that. We were told to work with those kids as is. We could not call them learning disabled and ADHD. They had to have a second diagnosis in order to get federal fundings for the schools.

It wasn't until 1997 IDEA that we were able to say the child is ADHD on their own, and stand on that merit on their own, and have federal monies funded to the school.

Ms. Robertson. I also want to make sure and clarify about the advertising with pharmaceutical company and CHADD. Any advertising from that pharmaceutical company is simply their name. It's not anything that would describe the drug or promote it.

Chairman Castle. I think we've completed all the questioning here. Let me just say this. It has been a very interesting hearing. You have been very good witnesses. I wish I could say all my questions were answered. If anything, this is kind of hearing I expected this, would raise almost more questions than it answers, in terms of where we have to go or what we have to do.

This was not a hearing which is designed to further a particular piece of legislation or a further activity of the federal government in any way. It was more a hearing to determine what is happening out there, what the problems may be, and the different avenues that perhaps we should explore, and we brought in a diverse group of individuals, both in the first panel and the second panel, to enlighten us on this, and we were very appreciative of that.

We may have further questions which we will submit in writing to you. We may not. We would hope you would help with that, but you have been very helpful in being here today, and hopefully this is the kind of hearing that will make a lot of people out there think about what we are doing. Are we doing the right thing? And that is we want to do the right thing, whatever that might be.

I don't know that answer. I am not enough of an expert at this point to know it. So, I do thank you very much, very sincerely, on behalf of the entire Congress, for being here today. Mr. Schaffer wants to make a quick comment, and then Mr. Kildee will make the final comment, and we'll close out.

Mr. Schaffer. I know the record is open to submit other comments, but I have had a constituent from Colorado who is here today and submitted some testimony he gave to me that he delivered before the Arkansas House of Representatives earlier this year, and I just want to share with the rest of the committee and state verbally on the record, I would like to submit that for the record as well at this point.

TESTIMONY OF BOB SEAY SUBMITTED BEFORE THE ARKANSAS HOUSE OF REPRESENTATIVES, AN ARTICLE FROM THE INVESTORS BUSINESS DAILY ENTITLED "PUBLIC SCHOOLS: PUSHING DRUGS?" AND ADDITIONAL MATERIAL SUBMITTED BY REPRESENTATIVE SCHAFFER – SEE APPENDIX J

Chairman Castle. That will be submitted, accepted for the record.

And you had an article from the Investors Business Daily which will also be accepted for the record. And we appreciate that. Mr. Kildee?

Mr. Kildee. I just want to thank all the witnesses today. You have been very, very helpful.

And I would like to thank you, Mr. Chairman, for scheduling this hearing.

Chairman Castle. Thank you very much, Mr. Kildee.

Again, we thank all of you for being here and for spending time. Sorry about the whole delay in the beginning of this. It unfortunately happens. Here we didn't have any other delays, which is good.

And we stand adjourned. Thank you.

[Whereupon, at 4:35 p.m., the subcommittee was adjourned.]

APPENDIX A – OPENING STATEMENT OF CHAIRMAN MICHAEL CASTLE, SUBCOMMITTEE ON EARLY CHILDHOOD, YOUTH AND FAMILIES, COMMITTEE ON EDUCATION AND THE WORKFORCE, U.S. HOUSE OF REPRESENTATIVES, WASHINGTON, DC

OPENING STATEMENT
THE HONORABLE MICHAEL N. CASTLE
CHAIRMAN,
SUBCOMMITTEE ON EARLY CHILDHOOD, YOUTH, AND FAMILIES

HEARING ON
"RITALIN USE AMONG YOUTH: EXAMINING THE ISSUES AND CONCERNS"

MAY 16, 2000
2:00 p.m., 2175 RAYBURN

THANK YOU FOR JOINING THE SUBCOMMITTEE ON EARLY CHILDHOOD, YOUTH, AND FAMILIES AS WE EXAMINE THE ISSUES AND CONCERNS SURROUNDING THE USE OF RITALIN AMONG OUR CHILDREN. I APPRECIATE EVERYONE'S INTEREST IN THIS TOPIC AND I LOOK FORWARD TO AN INFORMATIVE HEARING.

RITALIN IS PRESCRIBED TO HELP CHILDREN WHO HAVE ATTENTION DEFICIT DISORDER AND ATTENTION DEFICIT HYPERACTIVITY DISORDER, COMMONLY CALLED ADD/ADHD. OUR WITNESSES CAN PROVIDE A MORE THOROUGH EXPLANATION, BUT THE SYMPTOMS OF CHILDREN WITH ADD/ADHD CAN INCLUDE INATTENTION AND RESTLESSNESS -- WHICH MAY SIMPLY BE YOUTHFUL RAMBUNCTIOUSNESS -- OR IT MAY BE THAT THE CHILD IS ACTING OUT IN RESPONSE TO A SERIOUS STRESSOR LIKE DIVORCE -- OR IT MAY BE THAT THE CHILD DOES HAVE ADD/ADHD. THE BOTTOM LINE IS THAT IT IS DIFFICULT TO MAKE AN ACCURATE DIAGNOSIS -- ESPECIALLY AMONG YOUNG CHILDREN -- UNLESS THE PHYSICIAN THOROUGHLY EVALUATES ALL ASPECTS OF THE CHILD'S LIFE.

THAT SAID, ACCORDING TO STUDIES AND ANECDOTAL EVIDENCE, RITALIN CAN HELP STUDENTS FOCUS AND IT CAN CURB THEIR IMPULSES. KEEP IN MIND, HOWEVER, THAT RITALIN CAN HELP ANYONE BE MORE ATTENTIVE – IT'S AN AMPHETAMINE AND IT IS NOT TOO DISSIMILAR FROM SPEED.

AND, JUST BECAUSE RITALIN HELPS SOME CHILDREN, IT DOES NOT MEAN IT IS A CURE. AS A CONSTITUENT OF MINE ONCE PUT IT, KIDS CAN LEARN TO LIVE WITH THEIR LEARNING DISABILITIES AND THEY CAN DEAL WITH THEIR EMOTIONS IF THEY HAVE HELP. KIDS WHOSE SYMPTOMS ARE BANISHED WITH DRUGS ONLY GET DRUGS - NOT HELP AND NOT LONG-TERM SOLUTIONS FOR THEIR PROBLEMS.

IN LATE FEBRUARY OF THIS YEAR, A NEWS REPORT ON THE INCREASING USE OF RITALIN CAUGHT MY ATTENTION. I WAS PARTICULARLY ALARMED BY THE FINDING THAT FOR THE YEARS 1991 TO 1995, THE NUMBER OF CHILDREN AGES TWO TO FOUR WHO WERE PRESCRIBED PSYCHOTROPIC DRUGS, INCLUDING RITALIN, INCREASED BY 50 PERCENT.

THE RESEARCHERS COMMENTED THAT THESE FINDINGS WERE "REMARKABLE" GIVEN THE LACK OF RESEARCH ON THE DRUG'S EFFECT ON CHILDREN OF THIS VERY YOUNG AGE, AND THEY FOUND THAT SCHOOL AGE YOUTH ALSO SHOWED INCREASES IN THE USE OF RITALIN.

I INITIATED TODAY'S HEARING TO PROVIDE A FORUM TO DISCUSS THE ISSUES SURROUNDING THE USE OF RITALIN. PERSONALLY, I HAVE MANY CONCERNS ABOUT THE USE OF RITALIN. I HEAR REPORTS THAT STUDENTS ARE SELLING RITALIN AT SCHOOL AND THAT SCHOOLS ARE REPORTING THEFTS OF RITALIN UNDER THEIR CONTROL DURING THE SCHOOL DAY. I ALSO HEAR THAT YOUTH FIND IT EASY TO ABUSE THEIR OWN PRESCRIBED RITALIN OR A FRIEND'S RITALIN, SUCH AS BY SNORTING IT FOR A BETTER HIGH. AS WE ALL KNOW, RITALIN IS A SCHEDULE II DRUG -- REGULATED BY THE DEA -- YET IT IS A DRUG TO WHICH YOUTH HAVE RELATIVELY EASY ACCESS.

ADDITIONALLY, I AM GREATLY CONCERNED BY THE LACK OF RESEARCH ON THE LONG-TERM EFFECTS OF RITALIN. WE DO NOT KNOW WHAT THE LONG-TERM EFFECTS ARE FOR THE CHILD WHO TAKES RITALIN FOR TEN OR TWENTY YEARS. AS THE CHAIRMAN OF THE HARVARD MEDICAL SCHOOL'S DEPARTMENT OF PSYCHIATRY HAS STATED, THE PERIOD BETWEEN BIRTH AND AGE FOUR ESPECIALLY IS A TIME OF TREMENDOUS CHANGE AND MATURATION AND, AT THE VERY LEAST, WE NEED TO BE VERY CAUTIOUS IN BOTH THE IDENTIFICATION OF ADD/ADHD CHILDREN AND THE TREATMENT OF THESE CHILDREN.

FINALLY, THERE HAVE BEEN QUESTIONS RAISED WITH RESPECT TO THESE DRUGS AND ACTS OF VIOLENCE IN OUR CLASSROOMS. SOME USE AS EVIDENCE THE FACT THAT AT LEAST ONE OF THE GUNMEN IN

THE RECENT SCHOOL SHOOTINGS WAS REPORTED TO BE ON A DRUG LIKE RITALIN. WHATEVER THE ANSWER, WE NEED A SERIOUS DISCUSSION ABOUT WHETHER IT CAN CAUSE VIOLENT BEHAVIOR OR, IF NOT, WHETHER THESE DRUGS ARE SUFFICIENT TO PREVENT IT.

CLEARLY, THE CONGRESS AND THE PUBLIC NEED MORE INFORMATION IN ORDER TO WEIGH THE BENEFITS AND CONSEQUENCES OF PRESCRIBING RITALIN AND OTHER DRUGS TO OUR CHILDREN. AS WE WILL LIKELY HEAR FROM OUR WITNESSES, THE DECISION OF WHETHER TO USE RITALIN IS A DECISION TO WHICH THE CHILD, PARENTS, TEACHERS, AND DOCTOR SHOULD ALL HAVE INPUT. I BELIEVE THE INFORMATION DISCUSSED THIS AFTERNOON WILL ASSIST IN THIS DECISION.

THANK YOU.

APPENDIX B – OPENING STATEMENT OF RANKING MEMBER DALE KILDEE, SUBCOMMITTEE ON EARLY CHILDHOOD, YOUTH AND FAMILIES, COMMITTEE ON EDUCATION AND THE WORKFORCE, U.S. HOUSE OF REPRESENTATIVES, WASHINGTON, DC

DEK Remarks
ECYF Subcommittee Hearing on Ritalin Use
May 16, 2000

GOOD MORNING. I AM PLEASED TO JOIN CHAIRMAN CASTLE AT TODAY'S HEARING ON RITALIN USE AMONG OUR YOUTH. I KNOW THAT BOTH OF US ARE LOOKING FORWARD TO THE TESTIMONY OF OUR COLLEAGUES AND THE OTHER WITNESSES TODAY.

ATTENTION DEFICIT/HYPERACTIVITY DISORDER ROBS SO MANY OF OUR CHILDREN AND THEIR FAMILIES OF THEIR LIVES. BEHAVIOR PROBLEMS AND HYPERACTIVITY DOMINATE THEIR EVERYDAY EXISTENCE.

PARENTS OF CHILDREN WITH ADHD FIND THEMSELVES FRUSTRATED AND OFTEN TIMES AT WITS END. FORTUNATELY, RITALIN COUPLED WITH BEHAVIOR MANAGEMENT TECHNIQUES HAVE ENABLED THOUSANDS OF CHILDREN WITH ADHD AND OTHER HYPERACTIVITY DISORDERS TO ACHIEVE ACADEMICALLY AND THRIVE.

THE SUCCESS OF RITALIN AND RELATED MEDICATIONS IS WELL DOCUMENTED AND I AM SURE MUCH APPRECIATED BY PARENTS OF ADHD ACROSS THE NATION. HOWEVER, THE GROWING TRENDS OF RITALIN PRESCRIPTION AND ABUSE ARE A CAUSE FOR CONCERN.

THERE HAS BEEN A SHARP INCREASE IN RITALIN PRODUCTION AND PRESCRIPTION OVER THE LAST 10 YEARS. MUCH WORSE IS THE REALITY THAT RITALIN IS A DRUG THAT IS BEING PUSHED AND DEALT BY DEALERS AND CONSUMED BY CHILDREN LOOKING TO STAY AWAKE, SUPPRESS THEIR APPETITE AND OTHER REASONS. WHILE I KNOW THERE IS SOME DISAGREEMENT BETWEEN VARIOUS PARTIES OVER THE INCREASE IN RITALIN PRESCRIPTION, ITS OVERUSE AND OTHER CONSEQUENCES, I AM SURE THAT EVERYONE CAN AGREE THAT RITALIN ABUSE IS A GROWING PROBLEM IN OUR NATION.

RITALIN, AS PART OF A MULTI-MODAL APPROACH WITH BEHAVIOR MANAGEMENT TECHNIQUES, IS AND WILL CONTINUE TO BE A VIABLE TREATMENT OPTION FOR SOME CHILDREN AND ADOLESCENTS WHO HAVE ADHD. BUT THE DECISION TO USE RITALIN AS A TREATMENT OPTION SHOULD REST WITH A CHILD'S PARENTS AND THEIR DOCTOR. WE TRUST AND RELY ON MEDICAL PROFESSIONALS TO MAKE JUDGEMENTS FOR US EVERYDAY BASED ON THEIR KNOWLEDGE, EXPERIENCE, AND THE LATEST RESEARCH. THE SITUATION HERE IS NO DIFFERENT.

IN CLOSING, I WANT TO THANK CHAIRMAN CASTLE FOR HOLDING THIS HEARING AND LOOK FORWARD TO LEARNING FROM THE PERSPECTIVES OF OUR WITNESSES.

THANK YOU.

APPENDIX C -- OPENING STATEMENT OF THE HONORABLE BILL GOODLING, SUBCOMMITTEE ON EARLY CHILDHOOD, YOUTH AND FAMILIES, COMMITTEE ON EDUCATION AND THE WORKFORCE, U.S. HOUSE OF REPRESENTATIVES, WASHINGTON, DC

OPENING STATEMENT

CHAIRMAN GOODLING
COMMITTEE ON EDUCTION AND THE WORKFORCE

SUBCOMMITTEE ON EARLY CHILDHOOD, YOUTH, AND FAMILIES

HEARING ON

"RITALIN USE AMONG YOUTH: EXAMINING THE ISSUES AND CONCERNS"

MAY 16, 2000

2 PM, 2175 RAYBURN

Good afternoon.

It is estimated that Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder affect between 3 and 5 percent of children in the United States and boys more often than girls. I know that some children have such severe problems that medication is necessary, but I also hope the statistic I just mentioned does not include children behaving as normal active children. Children are active, they are inquisitive, and at times they do find it hard to harness all their energy. But we cannot rush to medicate them into acting like little adults.

I fear that too often parents and teachers turn to the quick fix of Ritalin. I know that it is much more difficult to teach a non-reading fifth grader how to read, than to suggest the child take Ritalin. Taking Ritalin will control the disruptive behaviors of the child who acts out in order to cover up an inability to read, but it will not teach that child to read.

We will hear this afternoon about the variety of treatments and interventions, aside from and along with medication, that can be used to help students who are having trouble in school. Children with significant attention disorders face extreme difficulties in academic and social settings. These children need a well-rounded approach toward improving their academic and social abilities. Today's hearing will raise awareness of the variety of ways to help students with attention disorders. For instance, some children need help learning appropriate behaviors and organizational skills through behavior intervention strategies, while others may need individually appropriate teaching strategies, such as hands-on learning and curriculum modifications.

I must stress that we should ask questions when a drug receives the attention that Ritalin has recently received. The Drug Enforcement Administration reports an increase from 2000 kg annually to over 14,000 kg annually in the production of Ritalin for the years 1990 to 2000, and an increase of 8 million in the number of Ritalin prescriptions written during the years 1991 to 1998. To me, these numbers cause great concern.

Are we over-medicating children and over-prescribing Ritalin? The answer cannot be found quickly, but in the meantime, hearings such as today's become all the more necessary. Students, parents, teachers, and doctors need to be informed of their treatment options.

I am also very concerned by the increasing drug trafficking of Ritalin – in schools. It appears that students bring an afternoon dose of Ritalin to school. Rather than take the medication, the child sells it or trades it to another student.

My concern is even greater knowing that Ritalin can have the same effect as cocaine. I understand it has a high abuse potential and can be addictive similar to cocaine. According to the Drug Abuse Warning Network, which gathers information from a limited group of hospital, the member hospitals saw in increase from less than 50 emergency room visits due to Ritalin in 1990 to almost 900 visits in 1997. While not nationally representative, these figures do illustrate the growing abuse of Ritalin.

Above all, the lesson I want parents, teachers, and doctors to leave today's hearing with is that they bear the responsibility of being informed of how best to help their child, student, and patient. Today's hearing will improve their knowledge of the competing concerns and issues regarding Ritalin.

APPENDIX D – STATEMENT OF THE HONORABLE DEBORAH PRYCE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Testimony of the Honorable Deborah Pryce (R-OH-15)
Hearing on "Ritalin Use Among Youth: Examining Issues and Concerns"
United States House of Representatives
Subcommittee on Early Childhood, Youth and Families
May 16, 2000

Thank you, Mr. Chairman and Members of the Subcommittee, for holding this important hearing and for giving me the opportunity to testify.

At the outset let me offer a disclaimer. I certainly am not an expert on Ritalin, psychiatric drugs, or child development. Instead, I appear before you as an elected official and representative to Congress who has heard from constituents who are very concerned about the increased use of Ritalin among children. I would like to describe for you their views as they relayed them to me.

In my position as a Member of Congress, the first time concerns about Ritalin were raised with me was in 1995, when I met with the Ohio State Board of Pharmacy. They were concerned about an increase in the use of Ritalin among school-aged children in Ohio and the pressure placed on school nurses and parents to put children on this drug. They suggested that some perverse financial incentives may be in play, in that schools receive more funding if more students were diagnosed with attention deficit disorder.

Payne ita

Another concern the Board of Pharmacy had was that the increase of Ritalin as a street drug was due to the over-prescription and misuse by some. Ritalin, intended for attention deficit children, was making its way to the "street corner."

More recently, I have been contacted by parents of school-aged children. The father of a six-year-old wrote to me because his child, who he described as a "handful" but "not out of control," was diagnosed with Attention Deficit Hyperactivity Disorder, also known as ADHD. Interestingly, this parent claims the teacher provided the diagnosis, and the school is pressuring the parents to put their child on Ritalin. The parents have tried to find alternatives to Ritalin that may change their son's behavior, but apparently the effects of these remedies are not dramatic enough to assuage the school's concerns about the boy's behavior. Therefore, my constituent remains under pressure to put his child on Ritalin, and he is under the impression that unless he complies with the school's suggestion, his son may no longer be able to attend school. According to the parents of this young boy, they are not alone in their predicament or concerns. They have met several parents locally who have had similar experiences.

Another constituent who wrote to me has an 11-year-old son who is active and, according to his mom, has trouble "sitting still in class." However, this mother does not believe her son has a behavioral problem, as he is respectful of adults and authority. The school has a different impression. A few years ago they began sending this mother pamphlets on ADHD. This mother claims that she was forced to take her son to the doctor, and he now takes drugs to control the problem. In the view of this parent, the school's pressure on her is due to their inability and unwillingness to discipline children, which in her view, is partly driven by the laws we legislators pass.

This particular parent makes another observation, which has also been reported in the press, which is that the use of these drugs may be related to violence in schools. My first thought is that it is not surprising that children prone to violence may also be candidates for the use of psychiatric drugs. However, one doctor who is opposed to the use of Ritalin told CBS news that she believes Ritalin, which she says is almost identical to cocaine, can *cause* dangerous behavior. This is a bold statement about a drug that has been in use for 40 years and which most physicians would probably tell us is safe. However, I bring it to the Subcommittee's attention because I know you have been studying the causes of school violence and working on legislation to reduce it.

I am not interested in placing any blame or judging these parents, their children, or the school personnel that must deal with mischievous and delinquent children. However, I do believe that my constituents raise issues that are worth further examination, including the role schools play in diagnosing ADHD and suggesting treatment.

This issue presents an interesting dynamic among schools, parents, and the medical community. At first blush, you would think that Ritalin is a medical issue, but the input from my constituents reveals that schools are very much involved. Unfortunately, doctors often cannot observe the behavior that prompts school personnel to suggest that the child may have a medical problem. Even the parents cannot see how their child behaves when he or she is out of their control and in a classroom environment among peers. It seems to me that making this type of health diagnosis is quite difficult and time consuming, yet I am not sure that anyone but the teachers have spent the time observing the behavior in question before children are diagnosed. I am pleased that the Subcommittee has also invited a teacher to testify today to provide a school's perspective.

I also am not prepared to question the effectiveness of Ritalin or other psychiatric drugs, nor do I have a comment about the doctors who prescribe these drugs to children. I am sure that these drugs have been proven quite effective in many cases. However, after receiving these letters from my constituents and reading recent reports about the growing number of very young children who are using psychiatric drugs nationwide, I felt congressional inquiry was warranted. I am sure that the Subcommittee is well aware of the report published in the Journal of the American Medical Association (JAMA) in February, which found that from 1991 to 1995, the number of 2- to 4-year-olds using such drugs, including Ritalin and Prozac, increased by 50 percent. I think this trend raises another important issue, which is relevant to the federal government's role in drug safety, though perhaps not in this Subcommittee's jurisdiction. And, my concern here is not just as a federal legislator, but also as the mother of a child who took numerous drugs and underwent very serious medical treatments for her illness. I think it is very important that we devote resources to study and provide better information to parents about the long-term effects of drugs on children.

It was just a few years ago that we heard about important discoveries in the area of brain development in children ages 0 to 3. In fact, studies show that 75 percent of brain growth development is in the first three years of a child's life. From a layman's perspective, it seems somewhat alarming to me that children as young as 2 years are taking psychiatric drugs, and I believe it is incumbent on the government to determine the risks of prescribing such drugs to very young children. In the FDA Reform Act, Congress provided an incentive to drug companies in the form of market exclusivity for testing their products on children. I think this is probably a good start. There are, of course, challenges in conducting medical studies on children, and I understand that it is not necessarily this Subcommittee's charge to sort out these issues, but I feel compelled to take this opportunity to mention the concern.

I want to reiterate that I am not here to cast judgement on individuals or the efficacy of any drug. However, it appears to me from the first-hand accounts of people in my community, that there is adequate public concern to warrant our attention. So, I thank the Subcommittee for holding today's hearing, which I hope will be helpful in improving our understanding of the many issues surrounding the growing use of psychiatric drugs by our children

Thank you, Mr. Chairman.

APPENDIX E -- STATEMENT OF THE HONORABLE DENNIS KUCINICH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Testimony
of
Rep. Dennis J. Kucinich (D-OH)

before the

House Education and the Workforce Committee
Subcommittee on Early Childhood, Youth and Families

May 16, 2000

Dear Mr. Chairman.

I appreciate the opportunity to testify before the Subcommittee on efforts to gather information on the increased use of Ritalin and related drugs by youth. I appreciate the opportunity to testify with my colleague from Ohio. Congresswoman Pryce. and to take a few minutes before your panel of expert witnesses to describe the situation experienced by my constituents in Cleveland and its western suburbs.

This issue first came to my attention following an investigative series by Cleveland's WKYC-TV. Channel 3. the NBC affiliate station serving northeast Ohio. In a revealing series of investigative reports. a series spearheaded by investigative reporter Phil Hayes, Channel 3 unearthed a pattern of abuses involving a number of young students in the greater Cleveland area whose parents were being pressured to seek a Ritalin prescription for their child by a small number of well-intentioned. but misinformed. school administrators and teachers.

What Channel 3 revealed was a disturbing pattern of abuses. where school teachers and administrators faced with a student with a discipline problem. an unruly student. or a hyperactive student. were using their positions as authority figures in the classroom to encourage parents to seek physicians for the sole purpose of obtaining a Ritalin prescription for their child.

Well-meaning teachers and counselors. with no real medical background. were unwittingly supplanting the judgment of a trained physician. whose diagnosis should be paramount in determining the cause and the solution for a student who may or may not be suffering from Attention Deficit Disorder. known as A.D.D.. or Attention Deficit Hyperactivity Disorder. known as A.D.H.D.

Imagine being a parent and having a school teacher or counselor say to you that the only way to help -- or save -- your child was to obtain a Ritalin prescription.

(more)

I am not a physician, but I have been in the classroom, as both a regular visitor in my local elementary, middle and high schools, and also as an instructor at the college level. I know firsthand the challenges teachers and school counselors face with unruly students with discipline problems. I know how frustrating it can be when one student can disrupt the learning opportunities of the entire classroom. And I recognize that parents of such children desperately want to find a solution -- any solution -- to help their child learn and to reach their full potential.

But what Channel 3 exposed was an apparent and alarming collective assumption by school officials that Ritalin was the *only* option that parents should seek to help their child address a behavioral problem, and that the advice of someone *other than a physician* could be instrumental in making that determination.

Ritalin may have its appropriate application in certain circumstances, and there certainly are a number of parents who are convinced that Ritalin helped their child overcome a behavioral problem. But that determination *must* be made by a qualified physician, in consultation with the child's parents or guardian.

Following the Channel 3 investigation, I worked with my Cleveland congressional colleague, Representative Stephanie Tubbs Jones, to have the Ohio Department of Education hold a number of seminars last fall throughout the State of Ohio for school administrators and counselors. The seminars focused primarily on the appropriate procedures for the identification and treatment of students with attention deficit and attention hyperactivity disorder.

This Subcommittee can play a meaningful role, as Channel 3 did, in educating school systems on the appropriate procedures that can help parents and children faced with this dilemma.

Ritalin should not be the *only* option forced on parents and their children. There *are* other options, and with the advice and determination of a qualified physician, parents can determine that there *may* exist a better option.

I appreciate the Chairman's involvement in this issue, and I look forward to today's testimony.

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APPENDIX F – STATEMENT OF MR. TERRANCE WOODWORTH, DEPUTY DIRECTOR, OFFICE OF DIVERSION CONTROL, DRUG ENFORCEMENT ADMINISTRATION, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, DC

Remarks by

Terrance Woodworth

Deputy Director
Office of Diversion Control
Drug Enforcement Administration
United States Department of Justice

before the

Committee on Education and the Workforce: Subcommittee on Early Childhood, Youth and Families

regarding

Ritalin – The Fourth R in Schools: Discussing the Use of Psychotropic Drugs for Youth

Rayburn House Office Building
Room 2175
Washington, D.C.
May 16, 2000

NOTE: This is the prepared text and may not reflect changes in actual delivery

Statement of
Terrance Woodworth
Deputy Director
Office of Diversion Control
Drug Enforcement Administration
Before the Committee on Education and the Workforce:
Subcommittee on Early Childhood, Youth and Families
May 16, 2000

Mr. Chairman, distinguished members of the Subcommittee, I want to thank you for the opportunity to address you today on behalf of the Drug Enforcement Administration (DEA) Acting Administrator, Donnie Marshall.

The DEA is the agency responsible for the regulation and control of substances with abuse potential that are subject to the Controlled Substances Act (CSA). In this regard, the DEA provides for the production of sufficient material to meet the legitimate need for controlled substances, but at the same time, minimizes the amount of these substances available for diversion. In striving to maintain this balance, the DEA has made every effort to keep the health and safety of our young people uppermost in our mind. Of the many psychoactive substances prescribed to young children in the United States, only two controlled substances are widely utilized by American physicians to treat children: methylphenidate (commonly known as Ritalin®) and amphetamine (primarily Adderall® and Dexedrine®). Both are approved and used in the treatment of attention deficit (hyperactivity) disorder referred to as ADHD or ADD. Both of these substances are powerful stimulants that have been in Schedule II of the CSA since 1971. Schedule II of the CSA contains those substances that have the highest abuse potential and dependence profile of all drugs that have medical utility.

In 1995, in response to a petition by Children and Adults With Attention Deficit Disorder (CH.A.D.D.) and the American Academy of Neurology to lower the regulatory controls on methylphenidate, the DEA conducted an extensive review of the use, abuse liability, actual abuse, diversion and trafficking of methylphenidate. The CH.A.D.D. petition characterized methylphenidate as a mild stimulant with little abuse potential – this is not what our review found and the petitioners subsequently withdrew their petition. In December 1996, the DEA held a conference on "Stimulant Use in the Treatment of ADHD". We gathered experts in the fields of ADHD research and treatment, psychiatry, social work, ethics and law enforcement who offered their expertise and unique perspectives to the many controversial topics related to ADHD and its treatment. In addition, the DEA participated in the 1998 National Institutes of Health (NIH) Consensus Conference. In 1998 and 1999, the DEA was invited to the Council of Europe to participate in joint meetings with the Pompidou Group and the International Narcotics Control Board (INCB) to discuss the control of stimulants in Europe and the diagnosis and treatment of ADHD with stimulants. Today, I will present a summary of the data we have gathered about the use of Ritalin and like drugs. These data show:

- The number of children diagnosed as having ADHD is unknown.
- Psychostimulants are effective in treating the symptoms of ADHD. Long-term studies looking at the effects of using these drugs are very limited.
- The medical use of stimulants in the treatment of ADHD in children continues to escalate.
- The expansive use of these drugs for childhood behavioral disorder in the United States differs significantly from medical practices in the rest of the world (United Nations data)
- The NIH Expert Panel (1998 Consensus Conference) concluded that the variability in physician diagnosis of ADHD as evidenced by areas of extremely high and low distribution and prescribing

rates of stimulants is suggestive of both over and under-diagnosis (Expert Panel, NIH Consensus Conference).

- Poison control data, emergency room data and high school surveys all indicate that the abuse of methylphenidate has increased significantly since 1990.
- A number of questionable practices have contributed to the diversion and abuse of stimulant medication including improper diagnosis, lack of adequate information to youth, parents and schools regarding the abuse potential of these drugs and lax handling of medication (Consensus statement, 1996 DEA Conference).

Production, Distribution and Prescription Data:

The DEA has observed a dramatic increase in the production and use of both methylphenidate and amphetamine. Each year, the DEA establishes an aggregate production quota (APQ) for each Schedule I and II controlled substance. This quota is based on sales and inventory data supplied by the manufacturers as well as information supplied by the Food and Drug Administration (FDA) regarding legitimate medical and research needs. The methylphenidate quota has increased from 1,768 kilograms in 1990 at which time there were 2 bulk manufacturers and 4 dosage-form manufacturers. This year, the APQ is 14, 957 kilograms with 6 bulk manufacturers and 19 dosage form manufacturers. Prior to 1991, domestic sales reported by the manufacturers of methylphenidate remained stable at approximately 2,000 kilograms per year. By 1999, domestic sales increased by nearly 500 percent. The amphetamine APQ has increased from 417 kilograms in 1990 with 2 bulk manufacturers and 7 dosage form manufacturers. This year's amphetamine APQ is 9,007 kilograms with 6 bulk manufacturers and 19 dosage form manufacturers. This is more than a 2,000 percent increase for amphetamine in nine years (See Figure 1).

The increases in production and use of methylphenidate are even more striking when compared to worldwide data (Figure 2). According to the United Nations the U.S. produces and consumes about 85 percent of the world's production of methylphenidate (INCB Report, 1999).

Figure 1.

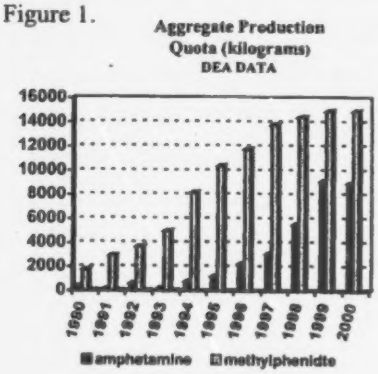
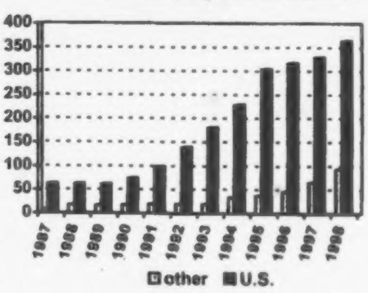


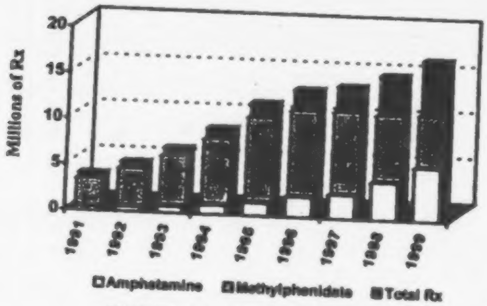
Figure 2.



IMS Health (a national prescription auditing firm) has provided the DEA with prescription data for amphetamine and methylphenidate. The vast majority of all prescriptions for amphetamine and methylphenidate (about 80 percent) are written for children diagnosed with ADHD. After sharp increases in the use of methylphenidate in the early 1990s, methylphenidate prescriptions have leveled off at about 11 million per year for the past four years. However, amphetamine prescriptions (primarily Adderall®) have increased dramatically since 1996: from about 1.3 million to nearly 6 million (see Figure 3). Collectively, this data indicates that the number of prescriptions written for ADHD has increased by a factor of 5 since 1991.

Figure 3.

Amphetamine and Methylphenidate Prescriptions



IMS Health, National Prescription Audit Plus™

More than 50 percent of all amphetamine and methylphenidate prescriptions are written by pediatricians. In addition, boys are four times more likely to receive a diagnosis of ADHD and be prescribed stimulant medication. In 1998, IMS estimated that about 40 percent of all prescriptions for ADHD were written for children 3 to 9 years of age and 4,000 methylphenidate prescriptions were written for children 2 years of age or less. It should be noted that methylphenidate is not approved for use in children under six years of age because safety and efficacy have not been established.

The DEA has a system known as ARCOS (Automation of Reports and Consolidated Orders System) that tracks Schedule II controlled substances from point of manufacture to a location where it will ultimately be distributed to the consumer. This system can be utilized to determine the amount of methylphenidate and amphetamine used in various localities. Analyzed on a per capita basis in entire states or by zip code areas within a state, ARCOS data indicates that there is wide variability in the use of methylphenidate and amphetamine from one state to another and from one community to another within the states. This variability are noted in a number of data sources and suggests both under and over-identification of ADHD. Most experts claim that the true prevalence of ADHD in the U.S. is about 3 to 5 percent. However, ARCOS data, prescription data and epidemiological studies have identified areas with almost no use of methylphenidate and communities with 10 to 20 percent or more of the student population receiving stimulants for ADHD treatment. The 1999 ranking for the states with the highest use of methylphenidate and amphetamine per 100,000 population are listed in Table 1.

Table 1. 1999 Methylphenidate and Amphetamine Distribution: Top Ten Users

DEA ARCOS DATA

	METHYLPHENIDATE		*AMPHETAMINE*	
RANK	***STATE***	***GRAMS PER 100K***	***STATE***	***GRAMS PER 100K***
1	New Hampshire	5,525	Delaware	2,538
2	Vermont	5,005	Rhode Island	1,903
3	Michigan	4,848	South Carolina	1,830
4	Iowa	4,638	Wisconsin	1,686
5	Delaware	4,439	Alaska	1,614
6	Massachusetts	4,318	Missouri	1,482
7	South Dakota	4,235	Arkansas	1,472
8	Virginia	4,207	Montana	1,431
9	Minnesota	3,941	Maryland	1,425
10	Maryland	3,935	Virginia	1,404

1999 Methylphenidate U.S. average = 3,082 grams per 100,000 population
1999 Amphetamine U.S. average = 1,060 grams per 100,000 population

California and Hawaii have the lowest per capita use of methylphenidate (1,748 and 1,208 grams per 100K, respectively) and New York and Hawaii have the lowest use for amphetamine (509 and 305 grams per 100K, respectively). A graphic representation of this data is seen in the figures below.

Figure 4

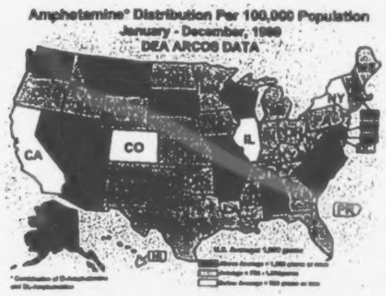
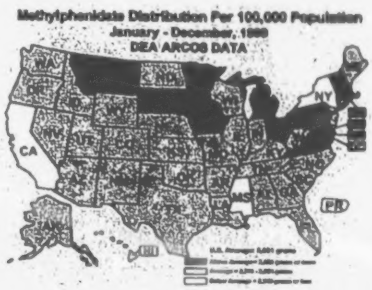

Amphetamine* Distribution Per 100,000 Population
January - December, 1999
DEA ARCOS DATA
CA
CO
IL
NY
PR
HI

Figure 5


Methylphenidate Distribution Per 100,000 Population
January - December, 1999
DEA ARCOS DATA
WA
OR
ND
NY
CA
MS
PR
HI

Abuse Liability

Extensive scientific literature spanning over 30 years of research unequivocally indicates that both methylphenidate and amphetamine have high abuse liabilities:

- They are self-administered by laboratory animals and humans;
- They produce discriminative stimulus effects similar to cocaine in laboratory animals and humans;
- They will substitute for each other and for cocaine in a number of paradigms in both animal and human subjects;

- Chronic high dose administration of either drug in animals produces psychomotor stimulant toxicity including weight loss, stereotypic movements and death; and
- In clinical studies, they produce behavioral, psychological, subjective and reinforcing effects similar to cocaine.

In more simplistic terms, this data means that neither animals nor humans can tell the difference between cocaine, amphetamine or methylphenidate when they are administered the same way at comparable doses. In short, they produce effects that are nearly identical.

Actual Abuse

A significant body of literature is available that describes the actual abuse of methylphenidate and consequences associated with that abuse. Like amphetamine and cocaine, abuse of methylphenidate can lead to marked tolerance and psychic dependence. Methylphenidate can be abused orally or tablets can be crushed and snorted or dissolved in water and injected. The pattern of abuse is characterized by escalation in dose, frequent episodes of binge use followed by severe depression and an overpowering desire to continue the use of this drug despite serious adverse medical and social consequences. Typical of other central nervous system stimulants, high doses of methylphenidate often produce agitation, tremors, euphoria, tachycardia, palpitations and hypertension. Psychotic episodes, paranoid delusions, hallucinations and bizarre behavioral characteristics similar to amphetamine-like stimulant toxicity have been associated with methylphenidate abuse. Severe medical consequences, including death, have been reported. Although the majority of the cases cited in the literature pertain to adults, case studies have profiled adolescents who abused their prescribed methylphenidate medication. This body of literature indicates that the improper use of methylphenidate can pose a serious risk or the user.

Unlike amphetamine, methamphetamine and cocaine where illicit manufacturing accounts for the vast availability of these drugs for abuse, pharmaceutical products diverted from legitimate channels are the only sources of methylphenidate available for abuse. Diversion of methylphenidate has been identified by drug thefts, illegal sales, prescription forgery, and various scams involving doctor shopping. From January 1990 to May 1995, methylphenidate ranked in the top ten most frequently reported controlled drugs stolen from registrants. From January 1996 to December 1997, about 700,000 dosage units of methylphenidate were reported to our drug theft database. In 1998 there were 376 reported thefts from pharmacies. Night break-in, armed robbery and employee theft are the three major sources of this diverted methylphenidate. In addition, the DEA has received a significant number of reports of methylphenidate theft at unregistered locations, primarily at schools and homes where methylphenidate supplies are kept. It is important to note that many schools have more methylphenidate on hand for student daytime dosing than is available in some pharmacies. While State and Federal laws require accountability of controlled substances by licensed handlers, no such requirements are imposed at schools.

The manner in which medication is handled at schools has provided an opportunity for some individuals to divert and abuse this medication. For example, a highly respected teacher was videotaped stealing methylphenidate from the nurse's office the evening of an awards ceremony that was honoring him as "teacher of the year." In another incident, a school nurse who was responsible for safeguarding student medications, stole the children's methylphenidate for her own use. In a school that required students to provide a doctor's prescription for proof of medication need, the principal was discovered taking the methylphenidate prescriptions, forging his name and filling them in pharmacies throughout the state for his own personal use. Students have been discovered taking medication from a teacher's desk where medication was being stored. A student who left home with a month's supply of medication, arrived at school with only six tablets having distributed the others to friends on the bus on the way to school. Schools have been broken into and medication supplies have been taken. In some of these reports, the school had no idea exactly how much or whose medication was taken. It is not at all surprising that these types of activities could occur. A 1996 DEA sampling of practices employed by schools for the handling of medication indicated that most schools did not have a nurse dispensing medication. Frequently supplies were kept in unlocked desks and a variety of people were tasked with giving medication to the students: school secretaries, parent aides, teachers and, in one school, the janitor was given that responsibility. Few schools kept records of drugs. At any given time, many schools may have no idea how much medication they should have. Although most schools had regulations prohibiting students from having drugs in their possession, many junior and senior high school students carried or administered their own medication.

Methylphenidate is sought after by a wide range of individuals. Information from DEA case files and State investigative services indicate that methylphenidate has been involved in criminal drug trafficking activities including:

- street sales as determined by undercover buys
- multi-state distribution rings
- multi-drug distribution rings (with cocaine, LSD, marijuana, hydromorphone, diazepam, anabolic steroids)
- smuggling from Mexico

In addition, numerous states have reported "Attention Deficit Scams" (a parent or other adult who takes a child who purportedly has ADHD to a number of physicians to obtain methylphenidate prescriptions- the adult obtains the drug for their own use or to sell or trade for other drugs).

The magnitude and significance of methylphenidate diversion and trafficking is comparable to pharmaceutical drugs of similar abuse potential and availability (like morphine sulfate). There is little doubt that Schedule II controls and the lack of clandestine production have limited the illegal use of this drug. However, reports of methylphenidate misuse/abuse among adolescents and young adults is particularly disturbing since this is the group that has the greatest access to this drug. Adolescents don't have to rob a pharmacy, forge a prescription or visit the local drug dealer to acquire methylphenidate – they have little difficulty obtaining it from a friend or classmate at school. Reports from numerous states and local municipalities indicate that:

- Adolescents are giving and selling their methylphenidate medication to friends and classmates who are frequently crushing the tablets and snorting the powder like cocaine.
- Anecdotal reports from students and faculty on college campuses indicate that methylphenidate is being used as a study aid and a party drug in the same manner that amphetamine was used on campuses in the 1960s.

The extent to which adolescents are abusing methylphenidate is unknown. The following data suggests that the number is small and has increased with the availability of this drug. In 1994, the national high school survey (Monitoring the Future) reported that about 1 percent of all seniors in the U.S. used Ritalin in the previous year without a doctor's order. In 1999, that percentage increased to about 3. In 1990, there were 271 estimated emergency room mentions for methylphenidate in DAWN

(Drug Abuse Warning Network). In 1998, there were 1,727 mentions for methylphenidate in DAWN of which about 56 percent were for ages 10 - 17. A 1996 DEA survey of three states (Wisconsin, South Carolina and Indiana) found that about 30 to 50 percent of adolescents in treatment centers were reporting "non-medical" use of methylphenidate although it was not identified as their primary drug of abuse. A 1998 Indiana University survey of 44,232 students found that nearly 7 percent of high school students surveyed reported using Ritalin illicitly at least once and 2.5 percent reported using it monthly or more often. Anecdotal reports relating to the illicit use of methylphenidate among children continue to be reported to DEA on a daily basis.

In conclusion, amphetamine and methylphenidate can significantly improve the symptoms of ADHD when these mediations are appropriately prescribed and used. However, the inappropriate use of these stimulants carries significant risks. The data show that methylphenidate has a high abuse potential. It is associated with diversion and trafficking and is abused for its psychic effects. The extent of these activities is similar to other pharmaceutical Schedule II substances. However, unlike other Schedule II drugs, methylphenidate is primarily prescribed to children. Information from physicians, parents, schools, poison control centers, adolescent treatment centers, surveys and law enforcement data, suggest that adolescents who are using this drug illicitly obtain it from individuals that have been prescribed this drug for ADHD. Probably the single most disturbing trend is that adolescents do not view abuse of this drug as serious. The DEA continues to urge the proactive effort of many groups including physicians, parents, school officials and law enforcement to evaluate the use of these drugs in their communities. Continued increases in the medical prescription of these drugs without the appropriate safeguards to ensure medication compliance and accountability can only lead to increased stimulant abuse among U.S. children.

Committee on Education and the Workforce

Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI. Clause 2(g)

Your Name:		
1. Will you be representing a federal. State. or local government entity? (If the answer is yes please contact the Committee).	[✓ Yes]	No
2. Please list any federal grants or contracts (including subgrants or subcontracts) which you have received since October 1. 1997:		
3. Will you be representing an entity other than a Government entity?	Yes	No
4. Other than yourself. please list what entity or entities you will be representing:		
5. Please list any offices or elected positions held or briefly describe your representational capacity with each of the entities you listed in response to question 4:		
6. Please list any federal grants or contracts (including subgrants or subcontracts) received by the entities you listed in response to question 4 since October 1. 1997. including the source and amount of each grant or contract:		
7. Are there parent organizations. subsidiaries. or partnerships to the entities you disclosed in response to question number 4 that you will not be representing?	Yes	No

Signature: Date: MAY 9, 2000

Please attach this sheet to your written testimony.

Biography for Terrance W. Woodworth

Terrance W. Woodworth is currently the Deputy Director of the Office of Diversion Control within the Drug Enforcement Administration (DEA) and has served in this position since September 1995. Mr. Woodworth has served in the following positions since joining DEA's predecessor agency, the Bureau of Narcotics and Dangerous Drugs, in 1972: Compliance Investigator, Dallas Texas; Group Supervisor, Kansas City, Missouri, and Louisville, Kentucky; Inspector, Office of Inspections; Special Assistant to the Assistant Administrator for Operations, Special Assistant to the Deputy Administrator; Chief, Drug Operations Section, Office of Diversion Control; and DEA's Deciding Official for Disciplinary and Adverse Actions.

Mr. Woodworth also established DEA's Diversion Office in Bonn, Germany, in 1978 and was later seconded to the International Criminal Police Organization (INTERPOL) in Paris, France.

Mr. Woodworth is a veteran of the U.S. Army, including service with the 101st Airborne Division in Vietnam.

Mr. Woodworth holds a BA Degree in Economics from Texas A&M University and an MS Degree in Management and Administrative Sciences from the University of Texas.

APPENDIX G – STATEMENT OF DR. LAWRENCE DILLER, BEHAVIORAL PEDIATRICIAN, BEHAVIORAL PEDIATRICS, CHILD AND FAMILY THERAPY, WALNUT CREEK, CALIFORNIA

Behavioral Pediatrics
Child and Family Therapy
Lawrence H. Diller, M.D.

Would Tom Sawyer Have Been Prescribed Ritalin?

(Appeared in the *San Francisco Chronicle*, March 18, 1999)

As a behavioral pediatrician for the past twenty years I have evaluated and treated over two thousand children for their behavior and school problems. I've written many Ritalin prescriptions, the stimulant used to treat ADD (short for Attention Deficit Disorder or hyperactivity). Beginning in the early 1990s, I began to see a new kind of ADD candidate, younger than six, teenagers and adults. Many of the children seemed far less impaired by their personalities compared to the previous generation of patients. Nevertheless, their parents and teachers were concerned.

I wondered if Tom Sawyer or Huck Finn was brought to my office tomorrow whether or not, after evaluating their family and school environments, they would ultimately leave with a prescription for Ritalin. I am not the only doctor writing more Ritalin prescriptions these days. The production and use of the drug has increased by 700% since 1990. In 1999 the United States used 80% of the world's Ritalin. What's behind this increase and why us?

The demands on children have grown while the social supports to them, their families and schools have decreased. There exists a rampant educational paranoia that declares everyone must get a college degree. Children are expected to learn earlier and more yet we have larger student-teacher ratios in the general education classroom. Parents are also working harder and longer which means less time for their children and more structured day-care and latch key kids. Parents are additionally handicapped by a cultural parenting philosophy that says, "if you know how to talk to Johnny he'll listen to you." Unfortunately,

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www.docdiller.com

from my experience if you try talking to ADD Johnny he's halfway down the street before you've finished your first sentence. More HMO healthcare means more "quick-fix" medication and being "labeled" ADD gets you special services at school.

Children in England and Japan use one-tenth the Ritalin we do so it couldn't just be today's fast paced life that makes us Ritalin unique among nations. Unlike those countries, we prize individuality and self-expression yet demand conformity at school. Limitations of class and intelligence are more accepted in London and Tokyo. Here we have the American Dream where anyone can be the next Bill Gates. We also believe in a "medical utopia" where all the problems of life can be solved by visiting the doctor and taking a pill. And our "state religion" is corporate consumer fundamentalism – material acquisition will lead to emotional and spiritual contentment. Performance enhancers like Ritalin, Prozac and Viagra are "in."

ADD is increasingly viewed by experts as biological and genetic. They say there is nothing "good" about an ADD personality. They compare impulsivity to having lower intelligence. I don't know how they can be so sure. Defining "what's good" is tricky business. Traditional IQ scores predict life contentment less well than "emotional intelligence." Theories of multiple intelligences include creativity. Many of our most "successful" people played off their temperament or learning weaknesses in school and developed valuable skills that served them and others well (once they left high school). Benjamin Franklin, Thomas Edison and Bill Clinton have all been described as "being ADD."

No doubt a core group of ADD children will struggle in any environment. But an intolerance of temperamental diversity currently exists in our country that views our present day Tom Sawyers as nothing but genetic detritus. Human diversity in the past has contributed to the richness of our culture and civilization. I worry about a society where there's no place for an unmedicated Tom. He is so many of our sons and daughters.

Extreme Ritalin

(Appeared in salon.com on April 4, 2000)

Ritalin was very busy last week. Twice, the controversial drug for the treatment of attention deficit-hyperactivity disorder (ADHD) made it to TV network news shows and the front pages of newspapers across the country. First, Hillary Clinton, in her capacity as children's advocate, announced that the National Institutes of Health would fund a multi-million study of ADHD and Ritalin use in very young children. This followed publication in JAMA of a survey which found that toddlers in increasing numbers were being given Ritalin and other psychiatric drugs. Later in the week, a story on the death of a college student from illegal use of psychiatric drugs also reported on the widespread availability of prescription stimulants on campuses throughout the country. A preliminary study from Wisconsin has found that one in five college students has used Ritalin, Dexedrine or Adderall without a doctor's supervision. The medications are usually obtained from students who've received the drug legally from a doctor for the treatment of ADHD.

These stories of Ritalin use at the extreme serve to highlight concerns that many doctors, school nurses and child psychotherapists have had for years over the increasing use of stimulants in our country. Ritalin production and use, nearly all for the treatment of ADHD, increased 700% in the 1990s. Only the most die-hard skeptics challenge the notion that something we call ADHD exists. The problem is defining who has and doesn't have the excessive impulsivity, inattention and hyperactivity which are the cornerstones of the ADHD diagnosis. Widely varying rates of Ritalin use attest to the subjectivity of the diagnosis. The answer to the question "Is Ritalin over or under prescribed?" is "yes" depending upon the community you assess and your threshold for the ADHD diagnosis and Ritalin treatment.

This problem is highlighted with Ritalin use now extending down to preschoolers. How much hyperactivity is "excessive" for a two or three year old? What is expected of a toddler these days that could constitute a problem great enough to require psychiatric medication? In what ways if any, has children's environment contributed to the problem by failing to provide the consistency of affection and discipline these children often need in abundance? While the toddler questions are grabbing the nation's attention these same issues apply to the use of Ritalin in school age children as well.

According to the JAMA survey, most of the toddlers taking psychiatric drugs were not getting any other services. This is also consistent with patterns of treatment for older children. That Ritalin "works" on the short term to improve the focus of children with ADHD is well known. That does not make Ritalin the moral equivalent or substitute of better parenting and schools for children. Some say we simply cannot afford the costs of effective non-drug treatments for ADHD. Ritalin is cheap compared to paying for parental counseling and smaller size classrooms. A Swiftian response might modestly propose the following: With about 4 million children currently taking Ritalin and classroom size averaging 30 kids per class why not increase the number of children taking Ritalin to 7.5 million so we could increase classroom size to 45 and save a lot of money.

A less well known fact is that Ritalin improves everyone's performance, child or adult, ADHD or not. College students are rediscovering a 100 years' worth of experience with the stimulants. It appears that every twenty years or so American doctors and patients lose their collective memories about the dangers of doctor prescribed stimulants. Our last epidemic occurred in the late 1970s when Dexedrine was used unsuccessfully as a diet aid and many women became addicted to the drug. Ironically, the only thing paradoxical about stimulant use for hyperactivity is that it is actually safer to use in children than with adults. Children do not self-medicate and they complain that they feel weird or nervous on higher doses -- not necessarily so for their adult counterpart ADHD sufferers.

America's century long love affair with the stimulants continues. No doubt there is a place for these drugs for a limited number of children and adults who are compromised in virtually any situation. But every day another Tom Sawyer and Pippy Longstocking get a Ritalin prescription because their round or octagonal personalities do not fit into the square educational holes of their school. Despite 60 years of stimulant use in children uncertainty remains about their long term effectiveness. The only thing for certain is that the controversy over Ritalin will continue.

Why Guidelines for Attention Deficit Won't Work

Last week the American Academy of Pediatrics (AAP) issued guidelines for the diagnosis and evaluation of Attention Deficit-Hyperactivity Disorder (ADHD), a problem, primarily in children, of excessive impulsivity, inattention and activity. Use of Ritalin, the controversial stimulant drug for ADHD has soared over the past ten years and the AAP guidelines are meant to bring some sense to the ADHD diagnosis and reassure an uneasy public about the overprescription of Ritalin.

Of late Ritalin has been in the news virtually every week. In February a study in the *Journal of the American Medical Association* found increasing use of Ritalin in toddler age children. Two weeks later Hillary Rodham Clinton announced her concerns about kids taking Ritalin. As a result a White House conference on psychiatric drug use in children is planned for this fall. Next came news that one in five college students are snorting Ritalin for "power studying" or just getting high. Finally, a medical examiner in Pontiac, Michigan announced that he had found pathological heart changes linked to long term, doctor-prescribed Ritalin use in a fourteen year old boy who died suddenly in March. Its meaning for the nearly four million children taking Ritalin is unclear but worrisome.

Since ADHD is the overwhelming reason for using Ritalin, prescription rates for the drug are a marker for the diagnosis. The Drug Enforcement Administration (DEA) keeps close tabs on Ritalin and its amphetamine sisters, Dexedrine and Adderall. DEA data show that Ritalin prescription use varies widely within the U.S. Michigan and Virginia tend to use four to five times per capita more Ritalin than Hawaii. Community rates within states vary even more, as much as twenty fold. Nationally, African and Asian American children are conspicuously underrepresented while one in five fifth grade white boys take Ritalin in certain Virginia school districts.

The subjective nature of the ADHD diagnosis is one of the reasons for the huge variability in Ritalin treatment. After hearing two days of expert testimony in front of the National Institutes of Health Consensus Conference on ADHD in 1998, the only pediatrician on the jury panel declared the diagnosis to be "a mess." Another prominent pediatric researcher has publicly called it "an embarrassment." Neither denies the existence of ADHD. Simply, the current concept of ADHD, as determined by American psychiatry in the

Diagnostic Statistical Manual (DSM-IV), and the practical realities of frontline primary care medicine create major confusion and contradictions on who should and shouldn't get Ritalin.

The AAP's efforts to bring order to this disorder simply won't work. First, the decision to use DSM criteria for ADHD diagnosis poses problems. According to the DSM a child either "has" or "doesn't have" ADHD. Black and white distinctions can be useful in research, but do not reflect the gray zone of ADHD in the real world where most of children being evaluated act only intermittently impulsive or are inattentive only in school. Many of these kids nevertheless get Ritalin. That DSM doesn't work for clinicians is reflected in a survey of nearly five hundred pediatricians, where less than one in ten used the DSM as their main criteria for diagnosis. Rather than arguing which children have or do not have ADHD it would be far more useful to decide what services or treatment each child needs. This kind of a "needs" based system is already in place for the treatment of mentally retarded children. Such a shift would be welcome for children's behavior and school problems also.

Furthermore guidelines, in general, do not influence doctors' practice very much. Doctors complain that the guidelines interfere with their "clinical judgment." But the AAP guidelines, like many others guidelines prepared by professional organizations, do not acknowledge perhaps the greatest factor affecting doctor and patient decision making -- money. In primary care economics overhead typically runs about 70% of gross income. Many doctors believe they would go broke if they devoted the time necessary to perform the evaluation for ADHD recommended by the AAP -- interviews with the parents and child, communicating directly with the teacher, ruling out other behavior and learning problems -- unless reimbursement for their time greatly increased. This is unlikely in the era of managed care medicine which has only exacerbated the economic pressures on doctors to act quickly. And parents, too, are reluctant to spend their own money for an adequate evaluation.

The common response of pediatricians and family doctors to reports of ADHD behavior at school or at home is, "Let's try the medication and see if it works." Such practice while saving time and money belies Ritalin's specificity for treating ADHD. Everyone, child or adult, ADHD or not, will focus better on tasks they find boring or difficult. Ritalin "works" on the short term but is not a moral equivalent of or substitute for better parenting and schools for children. In our hurried, performance driven society, performance enhancers, like Ritalin, for the truly disabled child or for those struggling in the gray zone, will be attractive as a less costly faster alternative to smaller class size or teaching parents more effective approaches with their children. More tolerance for the likes of today's Tom Sawyers and Huck Finns would also help slow the ADHD/Ritalin epidemic. The AAP guidelines are well meant but are not going to change much in the real world of children and their doctors. Only major shifts in our social values or perhaps more reports of sudden death in children on Ritalin are likely to affect the way we address and treat our children's behavior, personality and performance problems.

Lawrence H. Diller, M.D., practices behavioral pediatrics in Walnut Creek, California and is the author of *Running on Ritalin: A Physician Reflects on Children, Society and Performance in a Pill.*

Committee on Education and the Workforce

Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)

Your Name: LAWRENCE DILLER, M.D		
1. Will you be representing a federal, State, or local government entity? (If the answer is yes please contact the Committee).	Yes	No X
2. Please list any federal grants or contracts (including subgrants or subcontracts) which you have received since October 1, 1997: None		
3. Will you be representing an entity other than a Government entity?	Yes	No X
4. Other than yourself, please list what entity or entities you will be representing: none		
5. Please list any offices or elected positions held or briefly describe your representational capacity with each of the entities you listed in response to question 4: none		
6. Please list any federal grants or contracts (including subgrants or subcontracts) received by the entities you listed in response to question 4 since October 1, 1997, including the source and amount of each grant or contract: none		
7. Are there parent organizations, subsidiaries, or partnerships to the entities you disclosed in response to question number 4 that you will not be representing?	Yes	No ✓

Signature: Date: 5/10/01

Please attach this sheet to your written testimony.

APPENDIX H – STATEMENT OF MRS. FRANCISCA JORGENSEN, SPECIAL EDUCATOR, TAYLOR ELEMENTARY SCHOOL, ARLINGTON COUNTY SCHOOL SYSTEM, ARLINGTON, VIRGINIA

I am Francisca Jorgensen, a Special Educator employed with The Arlington County School System. I currently work with fifth grade students at Taylor Elementary School. Although I have worked with Arlington County for the past 12 years, I have also worked in a private school for students with Learning Disabilities in Washington, D.C. My current licensure endorses me to work with pre-Kindergarten through 12th grade students with Specific Learning Disabilities.

In addition to my full-time teaching responsibilities at Taylor Elementary, I also teach other educators through a group called The Connected University. My work with this group centers on technological innovations in today's classrooms, and I am assigned to guide a course called "Technology's Role in the Special Education Classroom." Recently, I served the United States Department of Education as a grants evaluator for the Preparing Tomorrow's Teachers to Use Technology initiative and I also judge online content for the ThinkQuest organization. Other projects have allowed me to work as a Teacher Advisor for The Kennedy Center and for PBS, and I have taught with PBS' National Teacher Training Institute on Math, Science, and Technology. In October, I will travel to Japan as a Fulbright Memorial Fund Teacher Participant.

My work experience has allowed me to observe and document student learning in an environment where every single child is impacted by learning disabilities, as well as in an environment where only some children among hundreds are impacted by these disabilities. Students whose learning disabilities are further compounded by Attention Deficit Disorder, with or without Hyperactivity, are a special circumstance and challenge for any classroom teacher.

At Taylor Elementary, our staff is dedicated to serving the needs of all students, with or without disabilities, in the least restrictive environment. Most often, this least restrictive environment is the general education classroom – an environment with an average of 25 students and one instructor. We have devoted an enormous number of hours to the professional development needs of our teachers at Taylor School, with special emphasis placed on environmental and behavioral modifications necessary to meet the varying needs of our students. We have enjoyed a great deal of success in our work with children of special needs. However, we continue to struggle with appropriately meeting the needs of our students who are impacted by Attention Deficit Disorders.

Identifying a student with Attention Deficit Disorder is not easy for any classroom teacher; however we these are some of the more common characteristics observed -

- An inability to pay attention for prolonged periods of time (often 15 minutes amount to a prolonged period of time).
- Great dependency on the teacher to individually interpret directions stated before the large group of students.
- An inability of executive functioning –these students experience a marked degree of difficulty beginning work, often requiring one-on-one assistance to begin projects.
- A necessity to have the instructor keep them focused on the task at hand. If this is not available, these students often do not complete assignments, and often earn grades of incomplete on classroom tasks.
- An inability to move from one task to another, often "stalling" on one activity and missing the instruction on the upcoming assignment.
- Constantly losing materials, books, homework assignments, and other classroom supplies.

- Getting utterly and completely lost in the school day, even while walking down the hall to the next class.
- A vacant response to the teacher's query for what the child needs, or where materials are, or what is next on the agenda.

It is no surprise, then, that students who are impacted by Attention Deficit Disorders are some of the most frustrated learners in a classroom. The frustration of these students do not go unnoticed or without close attention by our classroom teachers. A great deal of time, energy, and creativity go into modifying the school environment for these students.

Our successes in working with students impacted by ADD vary greatly, dependent on the individual child. It is not possible to ignore the environmental needs of these students. Our first course of action is to manipulate the learning environments in order to increase the chances for student success. Included in these external controls are to :

- Provide proximity control or an advantageous seating location for this student. This often is interpreted as placing that student at the front and center of the classroom, but for some students, this becomes disastrous, for now their inability to focus is exacerbated by the greater amount of stimulation that comes with the front of the room. In this case, we move students to alternate spots in the classroom until we find a more productive 'fit." This trial and error on simple seating arrangements for maximum productivity could conceivably occupy a teacher's time for several months. If there is more than one impacted child in that classroom, this "dance of the desks" is all consuming.

- Provide an individualized schedule, written out, and visually available for that student.
- Assign a "study buddy" to the student with attention problems. As in the "dance of the desk" routine, this may work sometimes, and may not work at all, dependent on the ability of the study buddy to complete their own assignments while attempting to focus a distractible child while the teacher is otherwise occupied with the other 23 students in the classroom. When a child needs one-on-one attention to complete assignments, this greatly impacts the ratio of time spent on the other 24 students in a class.
- Stabilize the school environment as much as possible for students impacted by ADD. Often there are special folders set in the same spot for the deposit of in-class or homework

assignments in order to lessen the likelihood that the student loses the assignment between one class and another.

- Secure a second set of textbooks for that student to keep at home, so that the child who often forgets his books at school can have a back-up system at home. This can become a costly system.
- Decrease the movement opportunities for students impacted by ADD. Holding a child in one class while the others switch to their subsequent sessions may sometimes work, but at other times, increasing the movement opportunities may be more beneficial. As with all situations outlined above, this is entirely dependent upon the unique needs of the child before us.
- Provide technological accommodations –a laptop perhaps, so the likelihood of losing papers is decreased.
- Provide a single person to whom the student reports to for help. Often this is the special educator on the teaching team.

But this, however, is a cautionary tale - One size does not fit all. For some students, a teacher's environmental modifications are enough, but for some students, the use of Ritalin is an academic and social necessity. Students who are unable to concentrate are unable to learn, and are unable to retrieve information and are unable to communicate in a classroom. The result is a child who lags further and further behind his or her peers, often to a social detriment. The decision to alter a child's natural body chemistry is not a decision that is made lightly at our school or in our homes. However, it is at this stage that behavior problems could add a new dimension to the problems already facing these students. Teachers may even feel responsible for a child's failure to attend to instruction because what had worked for another child in the past does not now work for the child before her.

For parents initially opposed to the use of Ritalin, it is often at this stage that the decision is made to intervene medically. Approaching a parent with the need for more than what is already provided in the classroom is an uncomfortable situation for our teachers, and can be met with either a conciliatory of accusatory response from parents. Fewer than 5% of our students at Taylor School use Ritalin to control their ADD symptoms, with others benefiting from the application of external controls, and another percentage who continue to flounder while the school works with the home to find some other formula that works.

Parents who vehemently refuse to accept that a medical intervention strategy is appropriate for their children may relent only when faced with the possibility that their child will fail coursework. This is often the catalyst to change in extreme circumstances.

The change that results from medically controlling the inability to concentrate is dramatic and profound. I have worked with students who, prior to medical intervention, were unavailable for instruction. These students become focused and determined learners once medical intervention is in place, often catching up on years of missed information.

Once medication is in place, a team effort is implemented to gauge new productivity levels in students. This team effort involves parent input, teacher input, and a doctor's close supervision. This is a process that I have frequently engaged in with families so that a proper determination could be made with regard to an appropriate dosage and individualized schedule for children. This medical strategy, coupled with environmental controls and solid teaching practices often yield compelling results. The use of Ritalin may not always be a necessity, but for some children, it is the difference between being learning and failing.

Committee on Education and the Workforce

Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)

Your Name: Francisca Jorgensen		
1. Will you be representing a federal, State, or local government entity? (If the answer is yes please contact the Committee).	Yes	No X
2. Please list any federal grants or contracts (including subgrants or subcontracts) which you have received since October 1, 1997: N/A		
3. Will you be representing an entity other than a Government entity?	Yes	No X
4. Other than yourself, please list what entity or entities you will be representing: N/A		
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7. Are there parent organizations, subsidiaries, or partnerships to the entities you disclosed in response to question number 4 that you will not be representing?	Yes	No X

Signature: Francisca Jorgensen Date: 5/16/00

Please attach this sheet to your written testimony.

BEST COPY AVAILABLE

FRANCISCA JORGENSEN

7409 Hogarth Street
Springfield, Virginia 22151
(703) 914-0539
fjorgensen.geo@yahoo.com

EDUCATION

Master of Education : **Special Education - Learning Disabilities,**
The American University, Washington, D.C. May 1988 Final G.P.A. 3.81

Bachelor of Arts : **Psychology and Spanish/Latin-American Studies,**
The American University, Washington, D.C. December 1985
Final G.P.A. 3.51 - cum laude
Minor in **Computer Science Programming**

POST-GRADUATE COURSEWORK

Including Special Students in the Regular Classroom, Shenandoah University
Succeeding with Difficult Students, Shenandoah University
Integrated Language Arts for Students with Special Needs, George Mason University

PROFESSIONAL EXPERIENCE

Special Educator : Grades K - 5
Taylor Elementary School, The Arlington County Public School System, Arlington, Virginia
June 1988 - Present

- Develop and implement an Inclusive Model Special Education Program serving students with Learning Disabilities, Emotional Disabilities, Attention Deficit Disorder, Vision Impairments, Orthopedic Impairments, and Cognitive Deficits through the Improving Special Education Experiences grant from the Virginia Institute for Developmental Disabilities.
- Chairperson of the Special Education Department.
- Team Leader of Grade 5.
- Mentor to newly hired Special Educators at Taylor School.
- Mentor to Lynbrook Elementary School, Fairfax County, Virginia.
- Webmaster of the Taylor Elementary School Website.
- Inservice Trainer : Website Design and Technology Integration.
- Inservice Trainer : An Introduction to IMac Technology.
- Grant Developer and Administrator : Improving SOL Scores.

Course Guide

Classroom Connect's The Connected University, Foster City, California
September 1999 - Present

Instructor in the Internet-delivered courses where educators earn Continuing Education Units through either Pepperdine University, Texas Tech University or the Mississippi Department of Education.

Teacher Advisor

ArtsEdge at The John F. Kennedy Center for the Performing Arts,
Washington, D.C.
September 1999 - Present

Serve on the focus group for the development of the ArtsEdge Website and other educational programs at The Kennedy Center.

Consultant

PBS/WNVT-53, Falls Church, Virginia
August 1999 - Present

Correlate PBS instructional videos with the Virginia State Standards of Learning. Correlations are published in the Catalog Instructional Television : Elementary, Middle School and High School.

Master Teacher

The Public Broadcasting Service's National Teacher Training Institute for Math, Science, and Technology, PBS/WNVT-53
Falls Church, Virginia
September 1996 - Present

Develop and present workshops to guide teachers in the successful incorporation of educational television, the Internet, and other modern technologies into instruction.

Technology Content Evaluator

ThinkQuest
Armonk, New York
August 1999 - May 2000

Evaluated Internet content developed by Educators and students for the ThinkQuest Program for Tomorrow's Teachers Program and the ThinkQuest Junior Program.

Technology Grants Evaluator

The United States Department of Education
Washington, D.C.
June 1999 - May 2000

Evaluated applications and made funding decisions for proposals submitted to the "Teaching Tomorrow's Teachers to Use Technology" initiative.

Internet Content Developer
The U.S. Olympic PBS Cyberschool Powered by IBM, PBS/WNET-13 , New York
September 1997 - March 1998
Developed Internet-based Challenges in Science, Math, Social Studies and Language Arts for this Public Broadcasting Service project.

Teacher Advisor
The Public Broadcasting Service, Alexandria, Virginia
March 1998.
Worked with a team to produce the video The Digital Classroom of the Future.

Summit Presenter
The Presidential Internet Online Summit, Washington D.C.
December 1997
Developed and presented an overview of educational practices as they relate to Internet content along with representatives from The Public Broadcasting Service, IBM, CBS, America Online and The Disney Corporation.

Spanish Teacher
The Lab School of Washington, Washington, D.C.
September 1987 - June 1988
Designed and implemented curriculum to teach Spanish as a second language to high school students with learning disabilities.

Counselor
The Educational Talent Search of The Spanish Education Development Center, Washington, D.C.
September 1985 - December 1985
Provided vocational counseling to both English- and Spanish-speaking students.

Assistant Instructor
The Department of Psychology, The American University, Washington, D.C.
January 1984 - May 1984
Served as Assistant Lecturer in a Psychology entitled course Behavior Principles.

PROFESSIONAL HONORS AND ACHIEVEMENTS

- Principal's **Commendation** : Development of a school website as a student project - June 1999

- Featured in the **Council for Exceptional Children's Video**, "Special Education and the development of Legal IEP's" - May 1999
- Featured in **The Learning Company's Online EZine** - March 1999
- Published in **Learning Kids Interactive Online Database** of Science Quizzes - March 1999
- Featured in **Education Week Magazine** - March 1998
- **Featured in the** Virginia Education Association Journal - March 1998
- Featured in the **PBS National Press Release** for the U.S. Olympic PBS Cyberschool Powered by IBM - **February 1998**
- **Featured in** WNVT Close Up - January 1998
- **Published in** Filamentality Online WebQuest Directory - December 1997
- Published in **The National** Teacher Training Institute's Compendium of Technology Lesson Plans - WNVT Edition, June 1997; National Edition, August 1997; WNVT Edition, June 1998
- **Featured in** The Arlington Education Association's Action Report - August 1997
- Letter of **Commendation** from the Virginia Commonwealth University and the Virginia Institute for Developmental Disabilities - June 1997
- Featured in the **Virginia Directory for Resources** - June 1997
- Featured in the **Council for Exceptional Children Newsletter** - March 1997
- Featured in the video **"An Educator's Introduction to the Internet"** - February 1997
- Featured in **The Virginia Sun** - November 1996

GRANTS

- **DreamWriters** - Purchased 36 laptop computers for use by students with special needs.
- **Tiger PAWS** - Purchased software to integrate Written Language into a preexisting Partner Reading program.
- **Project Neat** - Obtained free Internet access and a large-screen monitor for large-group Internet-based instruction.
- **Class Afloat** - Participated in an Internet-based yearlong Language Arts/Social Studies project in collaboration with high-school students circumnavigating the globe.
- **Nab the Net** - Purchased software to enhance the Internet experiences of students with special needs.
- **Content Connections** - Purchased content-area Reading material to enhance the Language Arts and Social Studies curricula for students with special needs.
- **Eager to Write** - Purchased monitor enhancements to accommodate students with special needs.

APPENDIX I – STATEMENT OF MARY ROBERTSON, BSN, RN, PARENT AND IMMEDIATE PAST PRESIDENT, CHILDREN AND ADULTS WITH ATTENTION DEFICIT/HYPERACTIVITY DISORDER, LEXINGTON, KENTUCKY

TESTIMONY OF
MARY ROBERTSON
LEXINGTON, KENTUCKY

RESPECTFULLY SUBMITTED
TO THE
U.S. HOUSE OF REPRESENTATIVES
EARLY CHILDHOOD, YOUTH AND FAMILIES
SUBCOMMITTEE

Tuesday, May 16, 2000
Washington, DC

Mary Robertson, RN and Parent
Immediate Past President CHADD National
2445 Brookshire Circle
Lexington, Kentucky 40515

Chairman Castle and Members of the Subcommittee, thank you for the opportunity to appear before you this afternoon. I speak to you today as a mother of two children with AD/HD, but my testimony represents millions of families that deal on a daily basis with the issues surrounding a diagnosis of AD/HD.

First, it is important for you to know that a diagnosis of AD/HD crosses all age, sex, socioeconomic, and racial boundaries. Second, it is not the parent who seeks the diagnosis of AD/HD. However, it is the parent who seeks help for their child who is struggling to succeed in school, at home and in the neighborhood. Parents turn to the medical profession for help. As you will hear from my story, it is not the parent who seeks medication. However, it is the parent who seeks help for their child who continues to struggle and fail. It is not the parent who gives up on the child with AD/HD. However, all too often, it is the schools, the doctors, and society who choose to deny the disorder exists and the devastation the disorder causes when left undiagnosed, or untreated.

Now, I knew our son, Anthony, was destined for greatness, however, his pre-school, our neighbors, family and friends sometimes had different opinions. One day the director of his day care called and asked me to pick him up. When I arrived, she requested that he not return. So much for trying to hold a job. I remember the heartache of packing up my son's belongings from his little cubby. Tears streamed down my face. I blamed myself for his inability to behave appropriately. As parents, it is our job to teach our children right from wrong, stop from go, and yes from no. As we left the day care center, the director told me that I should consider having him evaluated for "hyperactivity." I remember looking at her and thinking, "I know this kid is hyper, I don't need a doctor to tell me that." I had no idea of the implications of such a diagnosis. What I did know was that I deeply love and care for my son. If I had to remain at home to prepare him for the world, then that is what I would do.

However, his symptoms worsened. We decided to seek medical help. In 1990, Anthony entered the "Hyperactivity Clinic" at the University of Kentucky Medical Center. After three visits to the clinic, histories taken from his parents and teachers at the age of four, Anthony was diagnosed with AD/HD. We enrolled in the clinic's "Parenting Classes." I still did not understand the impact of the diagnosis. Although the classes were enlightening and helpful, we still pursued other possibilities for explanations to his impulsive and hyperactive behavior. I was trying everything in my power to help him, but it was not enough. We sought evaluations from a neurologist, then an allergist, then a hearing specialist, had his eyes checked, made repeated trips to his pediatrician, visited other psychiatrists and psychologists. We tried allergy shots, special diets, behavior management, accommodations and interventions. Nothing seemed to help.

I remember sitting in the first of the parenting classes listening to the other parents tell their stories. The stories were amazingly similar. It felt good to learn more about the diagnosis, new parenting skills, and possible interventions for school and at home. Then it came time for the last of the four classes. The topic: medication. I debated whether I even needed to attend this last session. I knew that I would go to the ends of the earth for my son, but I never, ever, would place him on medication for AD/HD. I was determined that my love and perseverance would be enough to overcome his behavior. After deciding that it was important to know everything associated with this disorder, I attended the last class.

Two weeks into his kindergarten year the phone began to ring again, just as it had done so many times during pre-school. His teacher knew that Anthony had been diagnosed with AD/HD, and wondered if he had ever tried Ritalin. She was genuinely concerned about him and had tried multiple accommodations within her classroom. We had all tried multiple accommodations. I feared the day that the word medication would be used in the same sentence as my son's name. I feared the idea that I would one day have to make a choice about medicating my child with a stimulant. But, now, as my son's struggles worsened, after trying everything the professionals told us to try, and if accommodations, interventions, counseling, behavior management and love were not enough, what I came to fear, was the possibility of medication NOT working.

He seemed to always be getting into trouble. He could not stay in his seat; not at home, church or school. His level of energy and movement caused things to spill, fall and break. His frustrations were beyond words. Blocks and chairs were thrown. Occasionally, he would have hysterical temper tantrums that would last for hours. Blinds ripped off windows, desks cleared of all items, objects thrown, as others in the room were left in a state of shock. On these occasions, I would have to hold him, sitting on the floor with my arms and legs wrapped around him so he could not harm himself. I would rock back and forth, as I held him, praying and silently crying until he would give way to exhaustion.

His impulsive behavior often got the better of him. Once, he found a hand saw that a construction worker left behind. When I called him in for lunch, he proudly walked in with the saw. He had nothing to hide. I very cautiously inquired as to where he found the saw, and what, pray tell, had he been doing with it? He cheerfully told me that he was sawing down a neighbor's new tree to see how many rings it had, so he could tell how old the tree was. There are several examples just like this that I could share with you, several which cost us time, money and our pride, but I do not have the time to share them today.

We had delayed a trial of Ritalin for as long as possible. Anthony began to fear and dread school. The few friends he had were beginning to stray. Then, one day after starting the first grade, he came home in tears. He ran through the door and flew straight to his bed. He cried and begged me to help him be like the other kids, he did not like getting in trouble every day, he could not remember how to spell, and he was tired of being sent to the hallway. After I calmed my son, I went to the telephone and called his pediatrician. The next week, Anthony started a trial of Ritalin. The change in his behavior, ability to pay attention and learn is not overstated as I say it was like watching a scene from Dr. Jekell and Mr. Hyde. The difference was unbelievable, and yet, the guilt of turning to medication took years to overcome.

Ritalin, it seemed, was a lifesaver, but it had drawbacks. His appetite was suppressed and getting enough food and nutrients in him was a challenge all its own. The side effects only caused me to feel further torment. While the medication was in his system, he was able to pay attention, remain seated and stay focus, make friends, and learn to read and write. However, when the medication wore off, all hell would break loose. In the medical field, this reaction is called "rebound." It is a cluster of symptoms experienced when medication wears off. In the case of Ritalin, many children experience rebound. The blood level of medication has dropped and the behaviors return, often with a vengeance, causing the child's behavior to appear worse than before the medication was given.

After a year of trial and error on the Ritalin, we opted for trying a different stimulant. This stimulant seemed to work as the Ritalin did, but Anthony did not experience the same rebound effect. Anthony remained on stimulant medication throughout elementary school. Despite his early rough start, when he attended his 5th grade graduation, he received multiple awards, including one for Good Citizenship, academic team, academic achievement, and the Outstanding Science Student award.

In middle school, the hormones kicked in, and as often happens during this time, the stimulant medications stop working. Regardless of his prior success and the fact that his home life remained consistent and accommodations were attempted within the school, Anthony began to struggle again. The struggles continued and worsened to the point that his anger overwhelmed him. He was no longer able to learn, or keep up with his peers. He spent so much time in the principal's office that he often missed entire chapters of subjects. By mid-year of the 7th grade, his world, our world, fell apart. He became clinically depressed and spoke of suicide. He was removed from school for 5 weeks and received treatment in a day program for 3 weeks. Recovery was not easy, but we began the long climb. Different medications were attempted. Finally, a combination of an antidepressant and a stimulant medication, along with counseling, an individualized education plan, and constant encouragement from his family, he seemed to once again focus and became available for learning.

In one week, he graduates from the 8th grade as an honor student. He is starting high school this fall and will be taking advanced classes. His goal is to become an aeronautical engineer.

As a parent of children with AD/HD and a member of CHADD, I welcome expanded governmental support for research on AD/HD, on the causes and treatment, as well as barriers to receiving an adequate diagnosis and treatment. I urge you to resist any effort to demonize people with AD/HD. These children are *our* children. Do not give into the sensationalism now associated with the name "Ritalin." To do so would be a grave injustice to the millions of children and adults who really do have AD/HD and want only to succeed in life. I would be happy to answer questions from Members of the Subcommittee.

Committee on Education and the Workforce

Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)

Your Name: Mary Robertson		
1. Will you be representing a federal, State, or local government entity? (If the answer is yes please contact the Committee).	Yes	No X
2. Please list any federal grants or contracts (including subgrants or subcontracts) which you have received since October 1, 1997:		
3. Will you be representing an entity other than a Government entity?	Yes X	No
4. Other than yourself, please list what entity or entities you will be representing: CHADD a parent based not for profit organization working for individuals with Attention-deficit/Hyperactivity Disorder.		
5. Please list any offices or elected positions held or briefly describe your representational capacity with each of the entities you listed in response to question 4: CHADD National Board of Directors 1995-Present CHADD National President 1998-1999		
6. Please list any federal grants or contracts (including subgrants or subcontracts) received by the entities you listed in response to question 4 since October 1, 1997, including the source and amount of each grant or contract:		
7. Are there parent organizations, subsidiaries, or partnerships to the entities you disclosed in response to question number 4 that you will not be representing?	Yes X	No

Signature: ____________________ Date: ____________________

Please attach this sheet to your written testimony.

PERSONAL INFORMATION: Please provide the committee with a copy of your resume (or a curriculum vitae) or just answer the following questions:

a. Please list any employment, occupation, or work related experiences, and education or training which relate to your qualifications to testify on or knowledge of the subject matter of the hearing:

C V Attached

b. Please provide any other information you wish to convey to the Committee which might aid the members of the Committee to understand better the context of your testimony:

Written Testimony Attached

Please attach to your written testimony.

CURRICULUM VITAE

March 16, 2000

NAME: Mary Teresa McClain Robertson, BSN, RN

Personal: Born: Mary Teresa McClain
January 8, 1958
Albuquerque, New Mexico
Married: Kent B. Robertson
September 17, 1983
Children: Anthony McClain Robertson
July 23, 1986
Samantha Grace Robertson
December 5, 1989
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Education

Eastern Kentucky University
Bachelor of Science in Nursing
Date of Graduation: December 1982

Eastern Kentucky University
Associate of Science in Medical Assisting
Date of Graduation: May 1997

Licensure

Kentucky State Board of Nursing
January 1983

Professional Experience

July 1999 – present: Immediate Past President and National Board Member, Children and Adults with Attention-Deficit/Hyperactive Disorder (CHADD)

July 1998 – June 1999: National President, CHADD

July 1997 – June 1998	President-elect, CHADD and National Board Member
May 1996 – June 1998	Director of the Columbia Mental Health Clinic for Attention Deficit Disorders
July 1996 – June 1997	Secretary, CHADD and National Board Member
July 1995 – June 1996	CHADD National Board Member
Feb. 1993 – June 1995	Coordinator, CHADD of the Bluegrass Lexington, Kentucky
Oct. 1988 – Dec. 1989	Clinical Nurse Manager Bone Marrow Transplant Unit University of Kentucky Medical Center Lexington, Kentucky
Dec. 1985 – July 1986	Division Charge Nurse Ambulatory Care Unit for Bone Marrow Transplants University of Kentucky Medical Center Lexington, Kentucky
June 1985 – May 1985	Oncology Nurse Clinician Grant Funded Research University of Kentucky Medical Center
Jan. 1983 – May 1985	Staff Nurse Bone Marrow Transplant Unit University of Kentucky Medical Center Lexington, Kentucky

Curriculum Vitae – Mary Robertson
Page 3 of 3

June 1978 – June 1980 Certified Medical Assistant/Clinical Specialty
Board Certified
Drs. Mayo, Long and Saha
Cardiothorasic & Vascular Clinic
Lexington, Kentucky

Committees and Professional Affiliations

Chairman, Discharge Planning Committee, University of Kentucky Medical Center

Co-founder of CHADD of the Bluegrass

Founder of the CHADD State Council of Kentucky

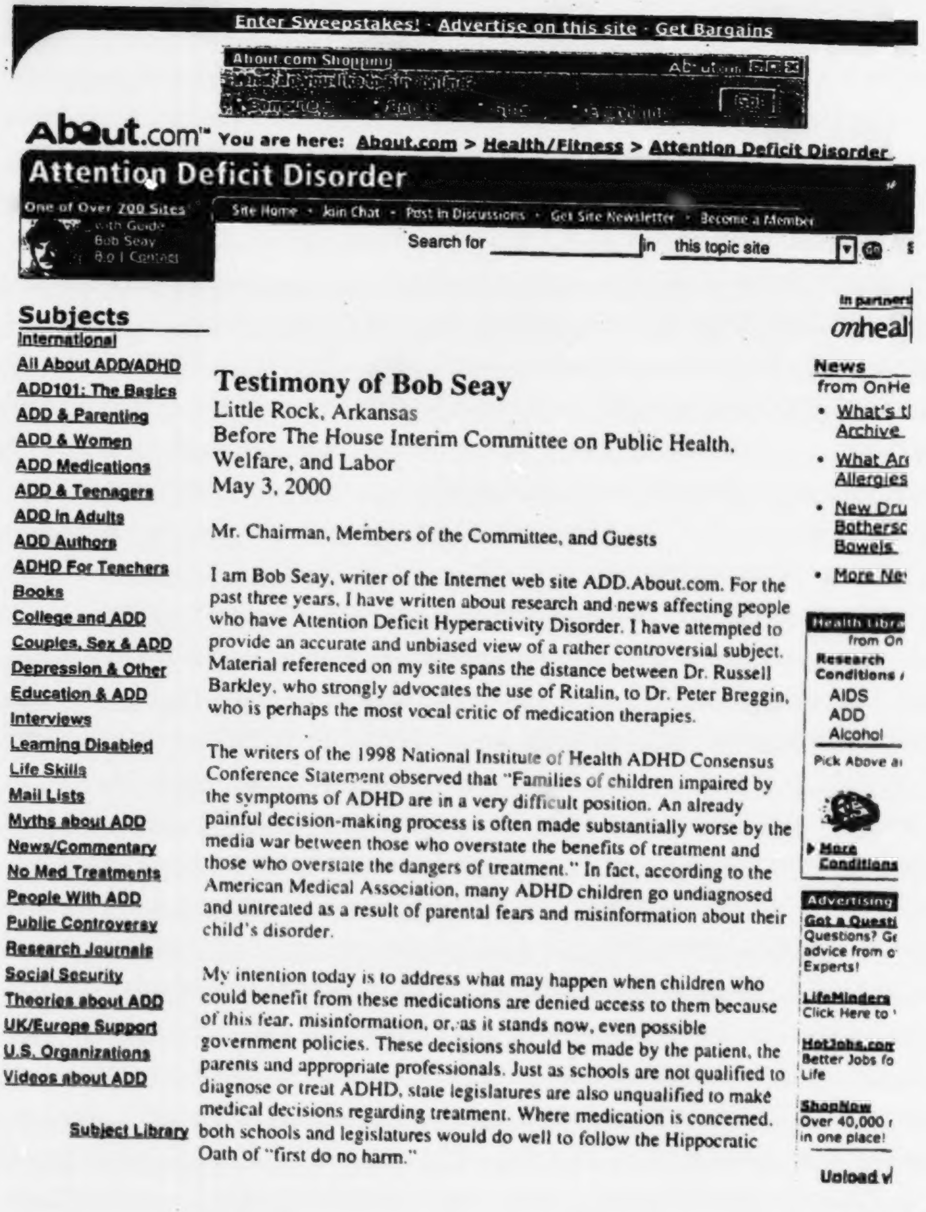
Fayette County Public Schools Parent Advisory Committee

CHADD National Chair Positions
  State Councils
  Government Relations and Advocacy
  Program
  ATTENTION! Editorial Board
  Leadership
  Field Service

Honors and Activities

CHADD National President Award - 1999
CHADD National Coordinator of the Year - 1994
BSN II, University of Kentucky Medical Center
Employee Commendation for Bone Marrow Transplant Projects

APPENDIX J – TESTIMONY OF BOB SEAY SUBMITTED BEFORE THE ARKANSAS HOUSE OF REPRESENTATIVES, AN ARTICLE FROM THE INVESTORS BUSINESS DAILY ENTITLED "PUBLIC SCHOOLS: PUSHING DRUGS?" AND ADDITIONAL MATERIAL SUBMITTED BY REPRESENTATIVE SCHAFFER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Testimony of Bob Seay

Little Rock, Arkansas
Before The House Interim Committee on Public Health, Welfare, and Labor
May 3, 2000

Mr. Chairman, Members of the Committee, and Guests

I am Bob Seay, writer of the Internet web site ADD.About.com. For the past three years, I have written about research and news affecting people who have Attention Deficit Hyperactivity Disorder. I have attempted to provide an accurate and unbiased view of a rather controversial subject. Material referenced on my site spans the distance between Dr. Russell Barkley, who strongly advocates the use of Ritalin, to Dr. Peter Breggin, who is perhaps the most vocal critic of medication therapies.

The writers of the 1998 National Institute of Health ADHD Consensus Conference Statement observed that "Families of children impaired by the symptoms of ADHD are in a very difficult position. An already painful decision-making process is often made substantially worse by the media war between those who overstate the benefits of treatment and those who overstate the dangers of treatment." In fact, according to the American Medical Association, many ADHD children go undiagnosed and untreated as a result of parental fears and misinformation about their child's disorder.

My intention today is to address what may happen when children who could benefit from these medications are denied access to them because of this fear, misinformation, or, as it stands now, even possible government policies. These decisions should be made by the patient, the parents and appropriate professionals. Just as schools are not qualified to diagnose or treat ADHD, state legislatures are also unqualified to make medical decisions regarding treatment. Where medication is concerned, both schools and legislatures would do well to follow the Hippocratic Oath of "first do no harm."

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The Arkansas Story: Lawmaker says "Yes" to guns, "No" to Ritalin

Now is the Time to Get Organized

Possible National Resolution Being Considered

Other States With Pending ADD/ADHD Resolutions or Legislation

Some of the testimony you will hear today will call into question the very concept of mental illness and the disorders that these medications are intended to treat. However, the United States Surgeon General's Report on Mental Health, released in December of 1999 begins with this comment: "The burden of mental illness on health and productivity in the United States and throughout the world has long been profoundly underestimated. Data developed by the massive Global Burden of Disease study, conducted by the World Health Organization, the World Bank, and Harvard University, reveal that mental illness, including suicide, ranks second in the burden of disease in established market economies, such as the United States.

According to the report of the Surgeon General, major depression alone ranked second only to ischemic heart disease in magnitude of disease burden. Schizophrenia, bipolar disorder, obsessive-compulsive disorder, panic disorder, and post-traumatic stress disorder also contributed significantly to the burden represented by mental illness. (Surgeon General's Report on Mental Health - online: http://www.surgeongeneral.gov/library/mentalhealth/chapter1/sec1.html) That same report also states that ADHD occurs in 3 to 5 percent of school-age children. (Surgeon General's Report on Mental Health - online: http://www.surgeongeneral.gov/Library/MentalHealth/chapter3/sec4.html)

Critics of the ADHD diagnosis cite the 1998 National Institute of Health ADHD Consensus Conference. In testimony given before the Pennsylvania House Democratic Policy Committee, in Philadelphia, Pennsylvania, July 20, 1999 , Bruce Wiseman stated that "a prestigious panel convened by the National Institute of Health just last November

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was unable to validate it as a disease." However, the actual Consensus Development Conference Statement reported that while there is to date no independent, valid test for ADHD "the diagnosis of ADHD can be made reliably using well-tested diagnostic interview methods", and that "evidence supporting the validity of the disorder can be found." (Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder. NIH Consensus Statement 1998 Nov 16-18; 16(2): online: http://add.about.com/health/add/library/weekly/blnih1st.htm)

Mr. Wiseman's testimony in Colorado indicated that 5 million children are on psychotropic medications. Yet, in his testimony, he lists only 12 cases of violence by criminals who may or may not have used these medications. Furthermore, the link between medication use and violence in even these 12 cases remains to be validated in any scientific manner. Although Ritalin has been used to treat ADHD for over 30 years and Dexedrine even longer than that, these acts of violence in our schools have surfaced only recently. Since medications were in use long before the event of mass murders in the public schools, we must ask ourselves what has brought about these horrible changes in our schools and our country over the past three or four generations of students.

Before prescribing medication, a patient and the doctor must consider the risk of treatment vs. the risk of non-treatment. In the case of ADHD, we know that the risk of medication treatment is extremely low. Despite the fact that Ritalin is a current media buzzword, the medication has been in use for over 30 years with very few complications. Ritalin is not the right medication for every ADHD patient, nor is it the only medication we are discussing here today. Other psychotropic medications have similarly lower rates of negative side effects.

The death of any child is a tragedy. That tragedy is made more profound when it is used to advance a specific agenda, as has been the case in much of the publicity surrounding psychotropic medications. Most recently, the death of 14-year-old Matthew Smith has been attributed by the coroner on the case as a result of Ritalin. According to his parents, Matthew had complained of heart palpitations and chest pain for some time before his death. Information contained in the Ritalin package warns patients and their parents about the possibility of such reactions and instructs them to notify their physician immediately if they occur. Had these instructions been followed, Matthew Smith would have either been taken off medication entirely or given a new medication. In any event, published research from the American Heart Association and other nationally respected institutions fails to support the findings of the local coroner. The coroner is on record as having said that he personally would not treat his children with medication, indicating a potential bias on his part.

The highly publicized case of Bryn Hartmann, who shot and killed her husband, comedian Phil Hartmann, before taking her own life has been blamed on Zoloft. Autopsy reports showed that Ms. Hartmann had used cocaine and alcohol on the night she killed her husband - a fact that is typically omitted from publicity about the case.

There are possible negative side effects associated with these medications. However, sensationalized claims of individual reactions need to be viewed in the larger perspective of all available data. According to Shire Pharmaeeuticals. there have been 10 reported cases of psychotic reaction to Adderall since the product was introduced. This is out of 7,000,000 prescriptions written over the past three years. Mania/hypomania was reported in 1% of patients treated with fluoxetine (Paxil) in controlled clinical OCD trials. Yet, if we were to believe what we read in the papers, these would be common events. Fortunately such is not the case.

Risks of ADD specifically without medication treatments are numerous and severe. They include:

Failure in School: Anywhere from 23 to 35% of children with ADHD will be retained at least once before entering high school, usually in the early elementary years. (Barkley, 1995)

Suicide: Research by Weiss & Hechtman (1986) indicates that almost 10% of ADHD individuals will attempt suicide and about 5% will die from either suicide or accidental injury. These percentages are much higher than in control populations - the general rate of suicide in the U.S. is about 11 per 100,000.

Substance Abuse: According to research by Dr. Joseph Biederman and colleagues at Massachusetts General Hospital in Boston, children who had received Ritalin or other drugs to control ADHD symptoms were at an 85% lower risk of substance abuse compared with ADHD children who went without medication. An earlier study in 1981 reported that adolescents who had not been medicated had more experience with marijuana and binge drinking, as well as more drunk driving and alcohol-related police contacts, than their medicated counterparts (Kramer, Loney, Whaley-Klahn, 1981)

Criminal Behavior: The California's Attorney General reports that "studies show that from 30 to 50 percent (depending on the study) of youth diagnosed as having ADHD by age 12 will be arrested by the time they are 18."

Greater Risk of Personal Injury: Researchers from Tufts University School of Medicine, in Boston report that ADD kids, when compared with Non-ADD Children, were more likely to be injured as pedestrians (27.5% vs. 18.3%) or bicyclists (17.1% vs. 13.8%), and to inflict injury to themselves (1.3% vs. 0.1%). They were more likely to sustain injuries to multiple body regions (57.1% vs. 43%), to sustain head injuries (53% vs. 41%), and to be severely injured as measured by the Injury Severity Score (12.5% vs. 5.4%) and the Glasgow Coma Scale (7.5% vs. 3.4%). The ADHD mean length of stay was 6.2 days versus 5.4 in the Non-ADD group. In both groups, 40% had surgery, but the ADHD children were admitted more frequently to the intensive care unit (37.1% vs. 24.1%). The injury led to disability in 53% of the children with ADHD vs. 48%

of the Non-ADD children.

The decision to medicate a child is never easy. It is one of the most agonizing decisions that a parent can face. Yet, in the overwhelming majority of cases, the results are positive. Grades improve, social skills improve, and, more importantly, many cases of tragedies such as substance abuse and suicide are avoided.

Please consider carefully the implications of the resolution before you. Consider the risk of medication vs. non-medication for ADHD and other mental disorders, and consider the overwhelming lack of any positive connection between these medications and violence. Finally, consider the potential harm done by the misinformation generated by such a bill.

We all want safe schools, and we are all concerned about the possible loss of our freedoms. But there are no short cuts and no simple answers.

To attempt to simplify such a complex problem as school violence by blaming it all on any one cause would be a disservice to the people of this state. To deny proven medications that have helped millions to have relatively normal lives would be cruel indeed.

Thank you for hearing my testimony today.

Bob Seay
May 3, 2000

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NATIONAL ISSUE

PUBLIC SCHOOLS: PUSHING DRUGS?

Gov't Money May Have Sparked Surge in Ritalin Use

By John Merline
Investor's Business Daily

Drug use is skyrocketing in schools. But it's the federal government that might be driving the trend

Every school day, more than a million children line up at nurses' stations to get their midday dose of Ritalin, a stimulant used to treat Attention Deficit Hyperactivity Disorder. Studies show that Ritalin use has nearly tripled since '90.

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The huge spike in use has set off alarm bells among some school administrators and health officials — not to mention law enforcement agencies.

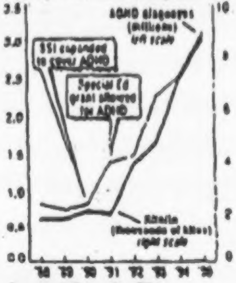
The Drug Enforcement Administration complains that the widespread use of Ritalin — which produces effects similar to cocaine and amphetamines — is generating a growing underground market.

And hospitalizations from Ritalin abuse are rising fast.

"A lot of people in the school business are leery of how much Ritalin is being prescribed these days," said Bruce Hunter, public affairs director at the American Association of School Administrators.

Ritalin's Rise

Since '90, Ritalin sales have shot up with ADHD diagnoses



Sources: IMS America, DEA

Largely overlooked, though, is the fact that at least some of the rise in Ritalin use might be traced back to two changes in federal programs.

In '90, the government opened the doors of a lucrative cash welfare program to low-income parents whose children are diagnosed with ADHD.

Then, in '91, the Education Department said schools could get hundreds of dollars in special-education grant money each year for every ADHD kid diagnosed.

While growth in ADHD diagnoses was flat for years prior to these changes, it has shot up an average 21% a year since, according to IMS America, a Plymouth Meeting, Pa., firm that tracks disease trends.

And Ritalin use, also flat in the '80s, took off like a rocket

"These program changes were factors," said Daniel Safer, an associate professor at the Johns Hopkins University School of Medicine, who studied the rise in Ritalin use. "I'm not sure how big they were. Nobody has measured it."

Safer and others argue that most of the hike stems from greater awareness of ADHD among parents and teachers, as well as treatments for it. Some 70% of ADHD kids take medication at one time or another, and almost all of those take Ritalin

In any case, they said, many children still go undiagnosed and untreated for the disorder, which can leave kids incapable of completing homework or answering questions on tests. Or it can cause them to be highly disruptive in class.

But the data suggest a link between money and Ritalin use.

In '90, a series of regulatory and congressional changes, along with a

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NATIONAL ISSUE: Public Schools Pushing Drugs?

Continued from front

Supreme Court ruling, opened the federal Supplemental Security Income program to kids with ADHD.

At the same time, Congress ordered SSI to launch a major outreach program to schools and welfare offices designed to enroll more children. State and local governments, along with advocacy groups, also touted the program.

The financial incentive to have a child labeled as having ADHD is powerful. Under the SSI program — which provides cash benefits to low-income elderly and disabled — an eligible family stands to get more than $450 a month for each child on the program. All but seven states add an average $110 a month into the pot. And once on SSI, families can get access to Medicaid and food stamps.

The result of the changes is clear.

In '89, children citing mental impairments that include ADHD, but not retardation, made up only 3% of all the disabled kids on SSI. That figure rose to nearly 25% by '95.

The new, looser rules also invite fraud, critics charge.

"We found that parents were actually coaching the children to do poorly in school and just basically act weird" to get on the SSI rolls, said Rep. Clay Shaw, R-Fla.

The General Accounting Office — a government watchdog agency — said it couldn't determine one way or another how prevalent fraud was. But it did note that the test used to determine a child's eligibility was "fundamentally flawed" — often making it too easy to qualify for benefits.

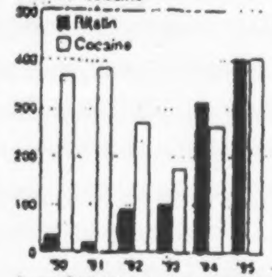
As part of its welfare reform bill, Congress last year tightened rules for getting on SSI. As a result, some 120,000 children were dropped from the disability rolls in recent months — many of whom had claimed ADHD.

The Education Department might have played a role in the rapid rise in Ritalin use as well.

In '91, it changed the eligibility rules for federal special education grants under its so-called IDEA program. After the change, schools could get more than $400 in annual grant money for each kid diagnosed with ADHD.

911 Ritalin

Number of emergency room visits for kids age 10-14 that mention Ritalin or cocaine



Source: Drug Enforcement Administration

"School districts are looking for funds," said an Education Department spokesman. The grants "give them an incentive to identify more kids with special education needs."

He said the department has been concerned that the ADHD grants could lead to "over-identification" of the disorder in schools.

Hunter dismisses any connection. Grant payments are too low, given the cost of providing special education, to push schools to boost the number of ADHD kids, he asserts.

Whatever the cause, critics of the high rates of Ritalin use point out that the drug — also known as methylphenidate hydrochloride — can have some serious side effects.

Among those known: loss of appetite, sleeping problems, stomach pain, weight loss, fast heartbeat, fever, joint pain, uncontrollable body movements and blurred vision.

Psychotic episodes and violent behavior are associated with chronic Ritalin abuse.

No studies have been done to look at the long-term health effects of prolonged Ritalin use.

On the other hand, the DEA noted that there is "little evidence of long-term benefits with stimulant therapy." Studies show that stimulants don't boost IQ or long-term academic performance.

"We don't use Ritalin to improve academic performance," said Alan Zametkin, a psychiatrist at the National Institute of Mental Health. "We use it to get their behavior under control."

Zametkin and other experts say Ritalin clearly works for about 70% of ADHD children.

But some worry that many children are misdiagnosed with ADHD — and put on Ritalin — when they might have other problems, or might simply be gifted children bored by school.

Highly creative kids, for instance, sometimes exhibit the same behavior as those said to have ADHD, says Bonnie Cramond, a professor of educational psychology at the University of Georgia.

She gave a test that measures creativity to more than 50 kids diagnosed with ADHD. More than a quarter scored high enough to qualify for a Creative Scholars program in Louisiana.

"The possibility that some highly creative children may be mistakenly tagged as ADHD is a concern," Cramond said. "The implications of misdiagnosing a highly creative child with ADHD may be dire."

A still bigger problem for critics is that abuse of the drug is on the rise. The DEA found a fivefold jump in the number of hospital admissions related to misuse of Ritalin since '91.

Schools often don't safeguard the drug carefully — although many have more Ritalin on hand than pharmacies, the DEA notes. That makes it fairly easy to make off with the drug and sell it to other kids who simply want to get high.

COLORADO STATE BOARD OF EDUCATION

RESOLUTION: PROMOTING THE USE OF ACADEMIC SOLUTIONS TO RESOLVE PROBLEMS WITH BEHAVIOR, ATTENTION, AND LEARNING

WHEREAS, the Colorado State Board of Education is constitutionally charged with the general supervision of K-12 public education; and

WHEREAS, the Colorado State Board of Education dedicates itself to increasing academic achievement levels for all students; and

WHEREAS, the responsibility of school personnel is to ensure student achievement; and

WHEREAS, only medical personnel can recommend the use of prescription medication; and

WHEREAS, the State Board of Education recognizes that there is much concern regarding the issue of appropriate and thorough diagnosis and medication and their impact on student achievement; and

WHEREAS, there are documented incidents of highly negative consequences in which psychiatric prescription drugs have been utilized for what are essentially problems of discipline which may be related to lack of academic success;

BE IT RESOLVED that the State Board of Education encourage school personnel to use proven academic and/or classroom management solutions to resolve behavior, attention, and learning difficulties; and

BE IT FURTHER RESOLVED that the State Board of Education encourage greater communication and education among parents, educators, and medical professionals about the effects of psychotropic drugs on student achievement and our ability to provide a safe and civil learning environment.

Adopted 11/11/99

NATIONAL BLACK CAUCUS OF STATE LEGISLATORS YOUTH COMMITTEE RESOLUTION

Subjects: The Use of Psychiatric Drugs on School-Age Children

WHEREAS, psychiatric drugs are prescribed to between five million and six million children each year - about ten percent of the school-age population, and

WHEREAS, Ritalin, perhaps the most common of these drugs, currently is administered to more than 2.5 million Americans, including more than one in every 30 children between the ages of five and 18, and

WHEREAS, the International Narcotics Control Board of the World Health Organization has warned about our nation's trend of overusing stimulants for children. According to the organization, the United States uses 90 percent of the world's Ritalin, and

WHEREAS, Ritalin is a schedule II drug, in the same category as opium, Morphine and cocaine, and

WHEREAS, it has been suggested that recent incidents of school violence and other occasions of violence are the result of children being unnecessarily medicated by such drugs;

THEREFORE, BE IT RESOLVED BY THE 23rd ANNUAL LEGISLATIVE CONFERENCE OF THE NATIONAL BLACK CAUCUS OF STATE LEGISLATORS, ASSEMBLED IN BALTIMORE, MARYLAND, DECEMBER 1st - 3rd, 1999, that the National Black Caucus of State Legislators strongly urges a national examination of the use of psychiatric drugs and their effects on children in this nation;

AND BE IT FURTHER RESOLVED, that the National Black Caucus of State Legislators affirms that Ritalin is a class II drug, and we resist the effort to have it downgraded to a lesser category.

PROPOSED RESOLUTION SUBMITTED BY:
Rep. LANETT STANLEY-TURNER (GA), YOUTH COMMITTEE

RESOLUTION APPROVED BY THE COMMITTEE ON YOUTH

APPROVAL CERTIFIED BY:
Rep. LANETT STANLEY-TURNER (GA), COMMITTEE CHAIR

RESOLUTION RATIFIED IN PLENARY SESSION, FRIDAY, DEC. 3, 1999.

RATIFICATION CERTIFIED BY:
Rep. JAMES THOMAS, NBCSL PRESIDENT

106TH CONGRESS
2D SESSION

H. RES. 459

Expressing the sense of the House of Representatives with respect to promoting the use of proven academic and classroom-management solutions for problems of behavior, attention, and learning in school children.

IN THE HOUSE OF REPRESENTATIVES

APRIL 4, 2000

Mr. SCHAFFER (for himself, Mrs. ROUKEMA, Mr. DEMINT, Mr. SAM JOHNSON of Texas, Mr. PAUL, Mrs. CHENOWETH-HAGE, Mr. LARGENT, Mr. CHABOT, Mr. BARTLETT of Maryland, Mr. NORWOOD, Mr. COBURN, Mr. LINDER, Mr. TANCREDO, Mr. HOEKSTRA, Mr. TERRY, Mr. GREEN of Texas, Mr. KUCINICH, and Mr. MCCOLLUM) submitted the following resolution; which was referred to the Committee on Education and the Workforce

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RESOLUTION

Expressing the sense of the House of Representatives with respect to promoting the use of proven academic and classroom-management solutions for problems of behavior, attention, and learning in school children.

Whereas the Constitution of the United States reserves to the States the responsibility for the general supervision of public education in kindergarten through the twelfth grade;

Whereas State and local education agencies are dedicated to increasing academic achievement levels for all students and ensuring that no student is left behind;

Whereas it is the responsibility of school personnel to ensure that all students achieve academically;

Whereas only licensed medical personnel have the authority to prescribe psychotropic drugs;

Whereas State and local education agencies, schools, parents, and children have expressed serious concerns regarding the appropriate and thorough diagnosis and medication of students and the impact on student achievement;

Whereas the Journal of the American Medical Association has documented that, among children aged two to four, the use of some psychotropic drugs has tripled between 1991 and 1995, and such findings are extremely troublesome given the very limited amount of research and clinical data that evaluates the safety and effectiveness of psychotropic drugs on the physical, cognitive, and emotional development of young children;

Whereas the number of American school children receiving prescription psychotropic drugs now approaches 6,000,000; and

Whereas there are documented incidents of highly negative consequences resulting from psychotropic drugs that have been prescribed for school children for what are essentially problems of discipline, and such prescriptions may be related to the lack of academic success by the children involved: Now, therefore, be it

Resolved, That it is the sense of the House of Representatives that the Congress should—

(1) exercise its oversight responsibilities and conduct hearings concerning the provision for

school children of prescriptions for psychotropic drugs;

(2) recommend that the National Academy of Sciences study the effects of prescription psychotropic drugs on the academic achievement and behavior of school children;

(3) acknowledge the efforts of State and local education agencies, and support their conclusions and resolutions, regarding the prevalence among school children of prescription psychotropic drugs and the growing crisis of classroom management;

(4) encourage school personnel to use proven academic and classroom-management solutions for problems of behavior, attention, and learning difficulties in school children; and

(5) urge greater communication between and education of parents, educators, and medical professionals regarding the effects of prescription psychotropic drugs on the academic achievement and behavior of school children and the ability to provide a successful, safe, and civil learning environment.

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EFF-089 (5/2002)